HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

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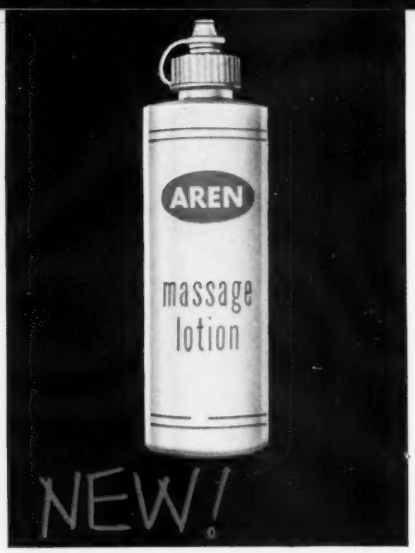
The News Magazine for Hospitals

OCTOBER | 1958



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HOSPITAL Topics
GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES
OCTOBER, 1958, VOL. 36, NO. 10

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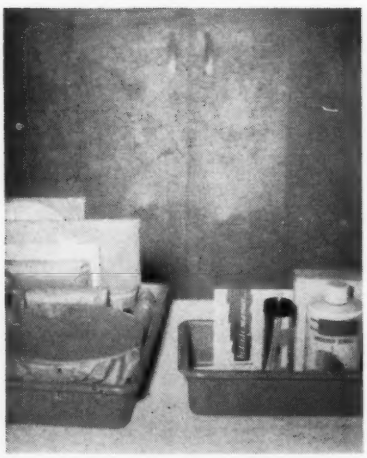

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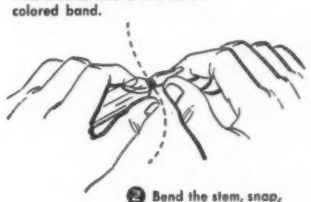

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1. Adams, Ralph, M. D. : Med. Times, 86:1119-1127 (Sept.) 1958.

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HOSPITAL *Topics*

PERSONALITY OF THE MONTH

RICHARD HIGHSMITH, president of the California Hospital Association, has been interested in hospitals and pharmacies since he was a young boy playing in his uncle's drug store in Upland, Calif. A year ago, as administrator of Samuel Merritt Hospital, Oakland, Calif., he helped Merritt obtain the first cobalt 60 irradiator in northern California.

His interest in establishing the cobalt unit in the hospital stems from the fact that in 1943 he became director of a new hospital in the then unknown town of Oak Ridge, Tenn. Shrouded in secrecy, a new community of over 100,000 people was springing up as work was rushed on the atomic bomb. Today, it is at Oak Ridge that natural cobalt is made radioactive.

Born in Lawrenceville, Ill., Mr. Highsmith moved to southern California when he was five. He graduated from the University of Southern California, Los Angeles, in 1936 with a B.S. degree in pharmacy.

Prior to Pearl Harbor, he served with the navy. It was during this period that he decided to go into hospital administration. After a medical discharge, he studied hospital administration at the University of Chicago. Following completion of the requirements for a master's degree, he became assistant administrator at Evanston (Ill.) Hospital.

From Evanston he moved to Oak Ridge and then to Children's Hospital of the East Bay in Oakland as administrator. He moved to Merritt in 1956.

Hospital organizations have played a large part in Mr. Highsmith's life. He has served as treasurer of the Association of Western Hospitals for two terms and has been chairman of the council on public education for the California Hospital Association.

He has served as president (1949-1951) of the East Bay Hospital Conference. He is also a member of the American College of Hospital Administrators and has been the California Association's delegate to the AHA.

Mr. Highsmith is married to the former Marian Groth and they have four children—Douglas, 9, Patrick, 7, Thomas, 5, and Richard, 3.

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HOSPITAL Topics
The News Magazine for the Hospital Staff

OCTOBER, 1958
VOL. 36, NO. 10

Scanning the News

Slides Dramatize X-Ray Benefits vs. Exposure Fear

"Radiation hysteria", has made millions of Americans unduly afraid of routine chest x-rays, Theodore H. Nehren, M.D., Buffalo, N.Y., told the recent meeting of the Student American Medical Association.

To dramatize his point, he showed x-ray slides taken at random of 100 people walking down the streets of Salt Lake City. Patients and physicians alike were amazed at the findings, which included heart disease, cancer, silicosis, esophageal and diaphragm disorders, and rib tumors.

Mobile Unit Evaluates Epileptic Patients

Mobile units, previously used in programs dealing with chest x-rays, hearing and speech disorders, diabetes detection, and blood donation, are now being used in epilepsy evaluation.

The Michigan Epilepsy Center and Association has a mobile unit for epileptic patients which carries an electroencephalograph to help determine the degree and type of epilepsy a person has.

For 10 weeks each year the unit tours areas lacking adequate study facilities. Local physicians refer their patients for EEG readings and neurological investigation. A neurologist at the Detroit center reviews the patient's reading, history and previous records, and sends suggestions to the patient's physician.

According to Z. Stephen Bohm, M.D., medical director of the center, the unit's visits have helped stimulate interest within communities in establishing permanent facilities for epileptic patients.

Benjamin W. Mandelstam, M.D. (center), administrator, Mount Sinai Hospital, Minneapolis, explains use of the pillow speaker, part of new closed-circuit television-radio system installed by the hospital, to patient Mrs. Myung Song while her husband, Kit Song, M.D., resident surgeon at Mount Sinai, looks on. The system allows patients to receive regular TV and radio programs, as well as internal broadcasts over the hospital's own Station WELL, via wall-mounted units. Individual pillow speakers have built-in controls which regulate volume, channel and station selection, permit use of set by one patient without disturbing roommate. The equipment, manufactured locally by The Dahlberg Co., is installed throughout the hospital with the exception of the pediatric section. It consists of 103 teleview units, 186 pillow speakers, a master amplified antenna system, and a master console for internal broadcasts, including a record turntable, recording machine, and mike. The hospital hopes to acquire a TV camera for its own telecasts.

Fast-Flying Releasin Frustrates Baghdad Stork

A K.L.M. Royal Dutch Airlines plane recently carried a package labeled "Non-narcotic — Life and Death Shipment" to Baghdad.

The package, which contained Releasin, was started on its way when a Warner-Chilcott Laboratories watchman got a call that the wife of an American oil company employee was threatened with the loss of her baby through premature delivery.

He located Carle Leslie, company traffic manager, who had access to the warehouse and refrigerators. A shipment was started on its way promptly.

At the other end of the line, the Releasin arrived in time to shoo off the over-anxious stork, and nature took its own time to deliver a healthy, seven-pound boy.

Isolation of Cytolipin H May Provide Cancer Clue

Maurice M. Rapport, M.D., and his associates at the Sloan-Kettering Institute, New York City, have isolated a fatty substance called Cytolipin H, common to the 20 most frequent forms of cancer.

The substance is present in the blood and urine of persons whose cancer is still too small to be detected by present methods of examination. Once its presence is ascertained, the site must be found.

News Briefs at Press Time

BARNES HOSPITAL TO BE CENTER OF STUDY OF INFECTIONS

Barnes Hospital, St. Louis, will be the center of a statewide program for the study and investigation of infections occurring in hospitals.

Focal point of program will be a study of the incidence and mechanisms of operative and postoperative infections, particularly staphylococcal infections, to be financed by a $78,250 three-year research grant from the John A. Hartford Foundation, New York City.

A complete laboratory will be set up at the hospital for investigation of surgical bacteriologic problems. State of Missouri will lend the hospital a microbiologist of the State Division of Health, to take charge of typing bacteria specimens from other hospitals in the state.

If a Missouri hospital reports a staphylococcal infection in one or more patients, a physician from the state health division will survey the institution and try to find the cause of infection. He will be assisted by staff members of PHS Communicable Disease Center laboratory, Atlanta, Ga.

Missouri is the first state to undertake such a program, according to H. M. Hardwicke, M.D., acting director of state health division.

HEW CONSIDERING INTERNATIONAL BUREAU TO PROVIDE EDUCATIONAL, HEALTH AID

Department of HEW is studying possibility of establishing an international bureau to provide educational and health aid to economically depressed countries.

Congressional visitors and expert observers (including TOPICS' consulting editor, John G. Steinle) have returned from abroad with criticisms of foreign-aid programs (see first three installments in Mr. Steinle's series, "The World and Medical Care," May, June, and July, 1958). Such programs either ignore health and educational needs of the countries, concentrating exclusively on economic development, or else make grants for education and health only when they are closely related to political or other concessions.

As a result of such criticisms, pressure is building up to remove this phase of the International Cooperation Administration from State Department jurisdiction.

PHS FIELD CONFERENCES DISCUSS SUGGESTIONS FOR H-B CHANGES

Series of field conferences is being held this fall by PHS Division of Hospital and Medical Facilities to obtain suggestions from state authorities and hospital administration leaders for changes in Hill-Burton Act. One conference is being held October 2-3 in San Francisco; another, October 8-9, in Asheville, N.C. One is planned for early December in New York.

Report on first 10 years of Hill-Burton just issued by PHS, can be obtained for $1.25 from Government Printing Office, Washington 25, D.C.

FTC DROPS CHARGES OF MISLEADING AD CLAIMS AGAINST INSURANCE FIRMS

Federal Trade Commission has dismissed charges of false and misleading advertising of health and accident insurance against United Insurance Co. and Lumbermen's Mutual Casualty Co., in accordance with recommendation by hearing examiners.

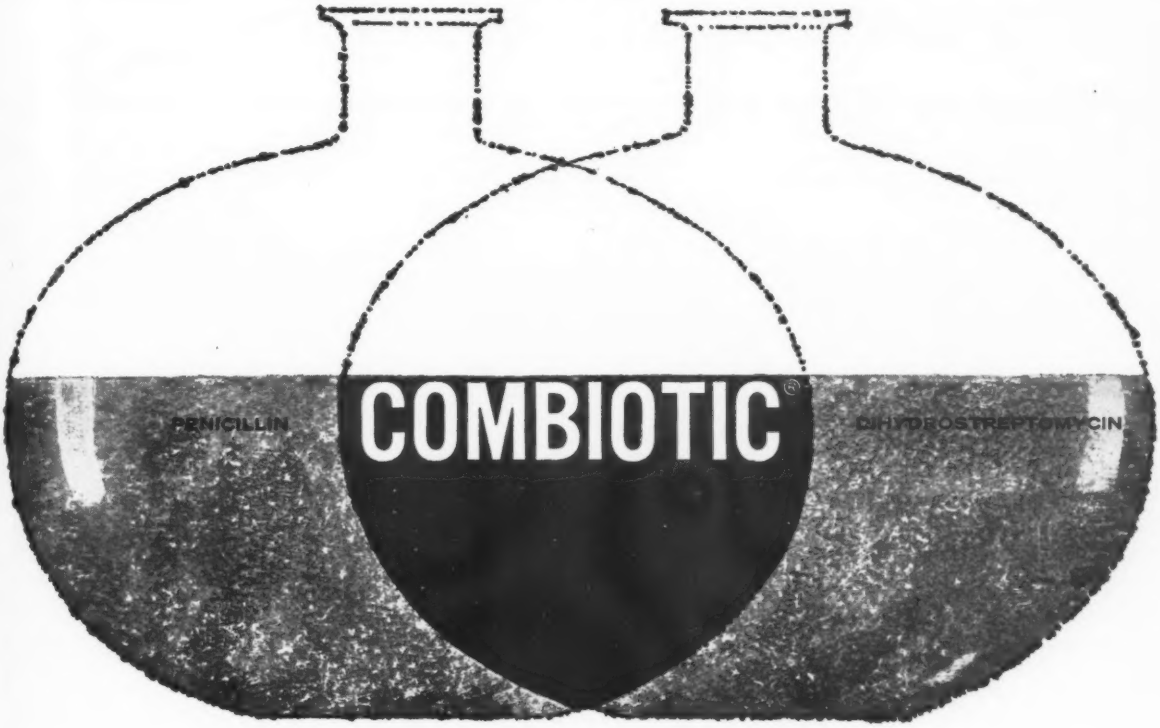
FTC opened crusade in October, 1954, against abuses in health insurance advertising. Charges were filed against 41 companies within a few months. But supports have been knocked from under all but a few cases by Supreme Court decision June 30 that FTC lacks authority to censure carriers' advertising in states which have regulatory controls.

BRIEF BRIEFS

Schools and universities will receive $6 million from the PHS in this fiscal year to be used to assist about 1,500 nurses to receive training in administration and supervisory and teaching methods...National conference on air pollution will be held in Washington, D.C., November 18-20.

Gordon M. Marshall

for routine treatment of commonly encountered infections and effective therapy in Upper Respiratory and Genitourinary Infections.



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SIMPLIFY ADMINISTRATION
DECREASE COST OF MEDICATION
REDUCE TIME OF TREATMENT
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1. Welch, H.: Antibiotic Med. 3:375. 1956

A-5377-8-8

Calendar of Meetings

OCTOBER

2- 3 AWH Institute, Improvement Through Forms, New Concepts of Departmental Management, Surf Rider Inn, Santa Monica, Calif.

6-10 American College of Surgeons, Conrad Hilton Hotel, Chicago

8- 9 Indiana Hospital Association, Indiana University Student Union Building, Indianapolis

8- 9 Vermont Hospital Association, Hotel Vermont, Burlington

9-10 AWH Institute, Housekeeping, Food Service, Maintenance, Hotel Hilton, Albuquerque, N. Mex.

10-12 National Association for Practical Nurse Education, Regional Workshop, San Rita Hotel, Tucson, Ariz.

12-17 American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago

13-14 Oregon Association of Hospitals, Gearhart, Ore.

13-15 Association of American Medical Colleges, Ocean House, Swampscott, Mass.

13-15 National Rehabilitation Association, Asheville, N.C.

13-16 American Association of Medical Record Librarians, Statler Hotel, Boston

15-16 Washington State Hospital Association, Winthrop Hotel, Tacoma

15-17 Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon, Sask., Canada

15-17 Symposium on Antibiotics, Washington, D.C.

16-17 Wyoming Hospital Association, Memorial Hospital of Natrona County, Casper, Wyo.

16-18 West Virginia Hospital Association, Daniel Boone Hotel, Charleston

17-18 American Rhinologic Society, Palmer House, Chicago

19-24 American Society of Anesthesiologists, Penn-Sheraton Hotel, Pittsburgh

20-21 Idaho Hospital Association, Hotel Boise, Boise

20-23 American Academy of Pediatrics, Palmer House, Chicago

20-24 National Safety Council, Conrad Hilton Hotel, Chicago

21 Hospital Association of Rhode Island

21-23 American Dietetic Association, Trade and Convention Center, Philadelphia

21-23 Associated Hospitals of Alberta, Jubilee Auditorium, Edmonton, Alb., Canada

22-24 California Hospital Association, Biltmore and Miramar Hotels, Santa Barbara

22-24 Association of State and Territorial Health Officers, Washington, D.C.

23-24 Mississippi Hospital Association, Hotel Heidelberg, Jackson

23-24 Nebraska Hospital Association, Omaha

24-28 American Heart Association, Civic Auditorium, San Francisco

25 American College of Osteopathic Hospital Administrators, National Institute, Statler Hotel, Boston

26-29 American Osteopathic Hospital Association, Statler Hotel, Boston

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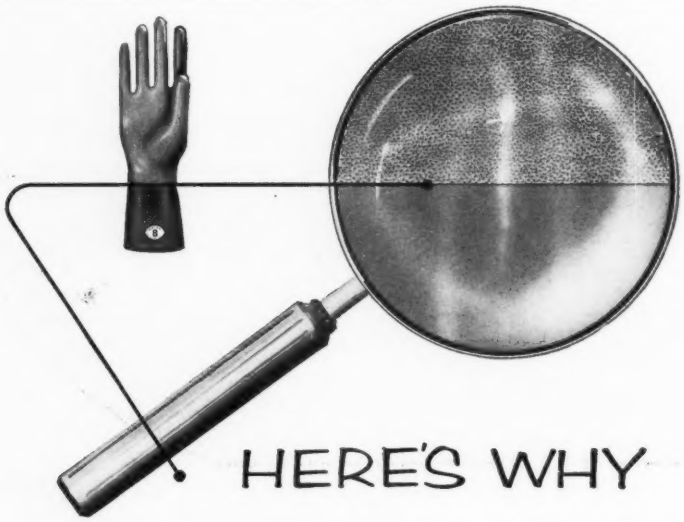

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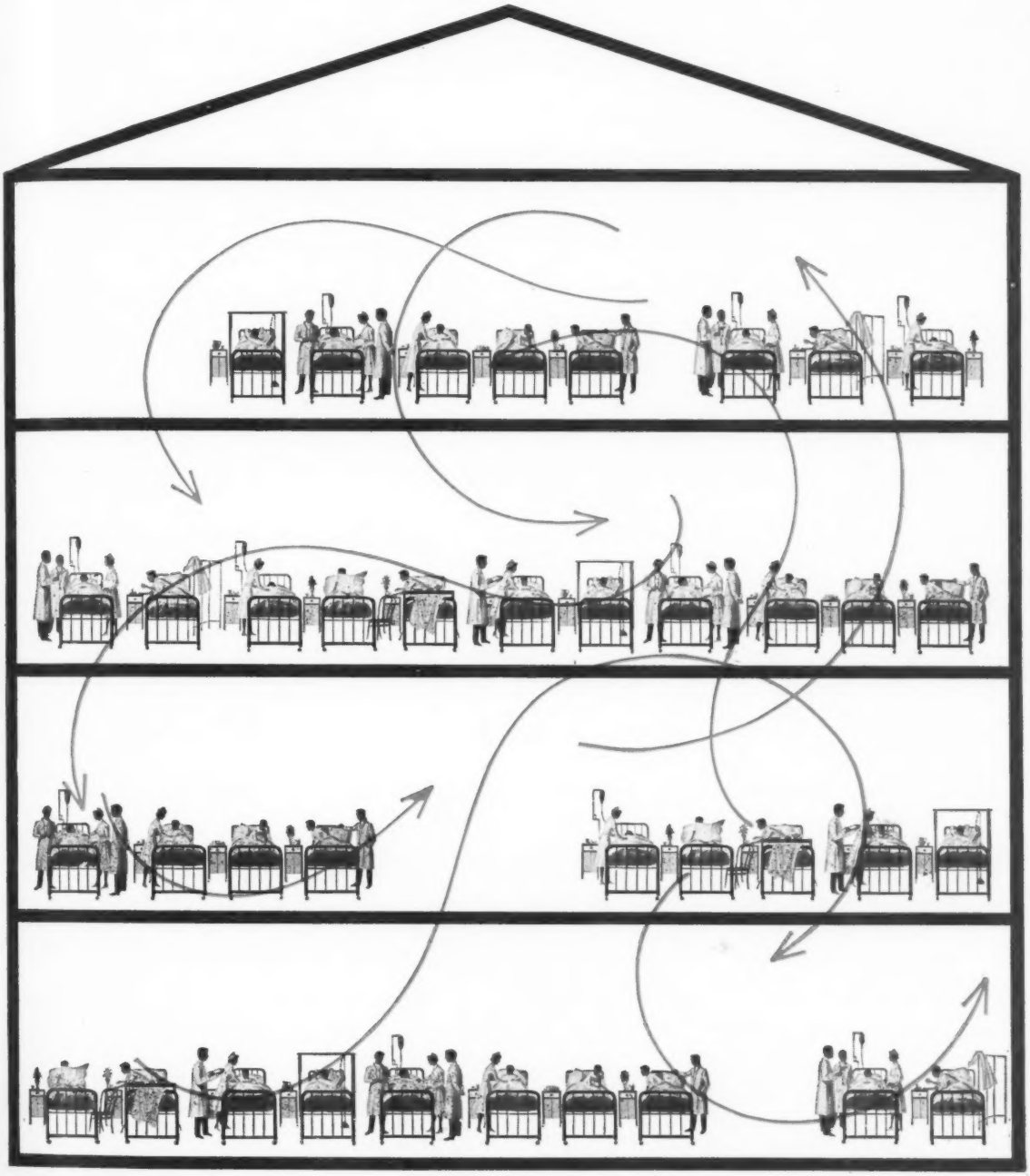

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CALENDAR OF MEETINGS

(Continued from page 10)

OCTOBER

27-31 American Public Health Association, Kiel Auditorium, St. Louis

28-31 British Columbia Hospital Association, Vancouver Hotel, Vancouver, B.C., Canada

31 AHA Financial Institute, Portland, Ore.

31-Nov. 2 American Association of Medical Assistants, Chicago

31-Nov. 2 Institute for X-Ray Technicians, American Society of X-Ray Technicians, American College of Radiology, Atlanta Biltmore Hotel, Atlanta, Ga.

NOVEMBER

1- 5 College of American Pathologists, Congress Hotel, Chicago

2- 8 American Society of Clinical Pathologists, Congress Hotel, Chicago

3- 5 Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D. C.

6- 7 Oklahoma Hospital Association, Skirvin Hotel, Oklahoma City

7 Minnesota Hospital Association, Lowry Hotel, St. Paul

10-13 Interstate Postgraduate Medical Association, Public Auditorium, Cleveland, O.

10-14 American Association of Inhalation Therapists, Kingsway-Ambassador Hotel, St. Louis

12-14 AWH Institute on Hospital Administration and for Hospital Auxiliaries, Princess Kaiulani Hotel, Honolulu, T. H.

13-14 Arizona Hospital Association, Westward-Ho Hotel, Phoenix

13-14 Kansas Hospital Association, Baker Hotel, Hutchinson

14-16 Virginia Hospital Association, Hotel Roanoke, Roanoke

16-18 National Association for Practical Nurse Education, Regional Workshop, New Hampshire Highway Hotel, Concord, N.H.

16-20 National Society for Crippled Children and Adults, Statler-Hilton Hotel, Dallas, Tex.

16-21 Radiological Society of North America, Chicago

17-18 International College of Surgeons, Mid-Atlantic Meeting, Homestead Spa, Hot Springs, Va.

17-19 Association of Military Surgeons of the U.S., Hotel Statler, Washington, D.C.

18-20 First National Conference on Air Pollution, U. S. Department of Health, Education and Welfare, Sheraton Park Hotel, Washington, D. C.

18-20 AHA Institute, Disaster Planning, Ambassador Hotel, Los Angeles

19-21 Missouri Hospital Association, President Hotel, Kansas City, Mo.

20-22 American Association of Blood Banks, Netherlands Plaza Hotel, Cincinnati, O.

20-22 Western Surgical Association, Kahler Hotel, Rochester, Minn.

21-23 National Association for Practical Nurse Education, Regional Workshop, Willard Hotel, Washington, D.C.

(Continued on page 14)

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CALENDAR OF MEETINGS

(Continued from page 12)

DECEMBER

1- 5 AHA Institute, Methods Improvement, Cosmopolitan Hotel, Denver

2- 5 American Medical Association, Clinical Meeting, Municipal Auditorium, Minneapolis

6-11 American Academy of Dermatology and Syphilology, Palmer House, Chicago

8-12 AHA Institute, Hospital Housekeeping, Ambassador Hotel, Los Angeles

9-11 Southern Surgical Association, Boca Raton Club & Hotel, Boca Raton, Fla.

26-31 American Association for Advancement of Science, Washington, D.C.

1959 MEETINGS

January 27-30—American Protestant Hospital Association, Jefferson Hotel, St. Louis

January 27-29—National Association of Methodist Hospitals and Homes, Jefferson Hotel, St. Louis

February 4-5—AHA Midyear Conference of Presidents and Secretaries, Palmer House, Chicago

February 4-7—American College of Radiology, Chicago

February 9-11—Association of Operating Room Nurses, Shamrock-Hilton Hotel, Houston, Tex.

March 23-25—New England Hospital Assembly, Hotel Statler, Boston

March 31-April 2—Kentucky Hospital Association, Phoenix Hotel, Lexington

April 1-3—Mid-West Hospital Association, Municipal Auditorium, Kansas City, Mo.

April 6-9—Ohio Hospital Association, Veterans Administration Auditorium, Columbus.

April 8-10—Southeastern Hospital Conference, Atlanta-Biltmore Hotel, Atlanta, Ga.

April 16-17—Carolinas-Virginias Hospital Conference, Hotel Roanoke, Roanoke, Va.

April 27-29—Tri-State Hospital Assembly, Palmer House, Chicago

April 27-May 1—National Association for Practical Nurse Education, Netherland Hilton Hotel, Cincinnati, O.

May 4-7—Association of Western Hospitals, Hotel Utah, Salt Lake City

May 11-15—National League for Nursing, Philadelphia

May 12-14—Texas Hospital Association, Shamrock-Hilton Hotel, Houston

May 13-15—Upper Midwest Hospital Conference, St. Paul Auditorium, St. Paul, Minn.

May 20—New Jersey Hospital Association, Convention Hall, Atlantic City, N.J.

May 20-22—Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City

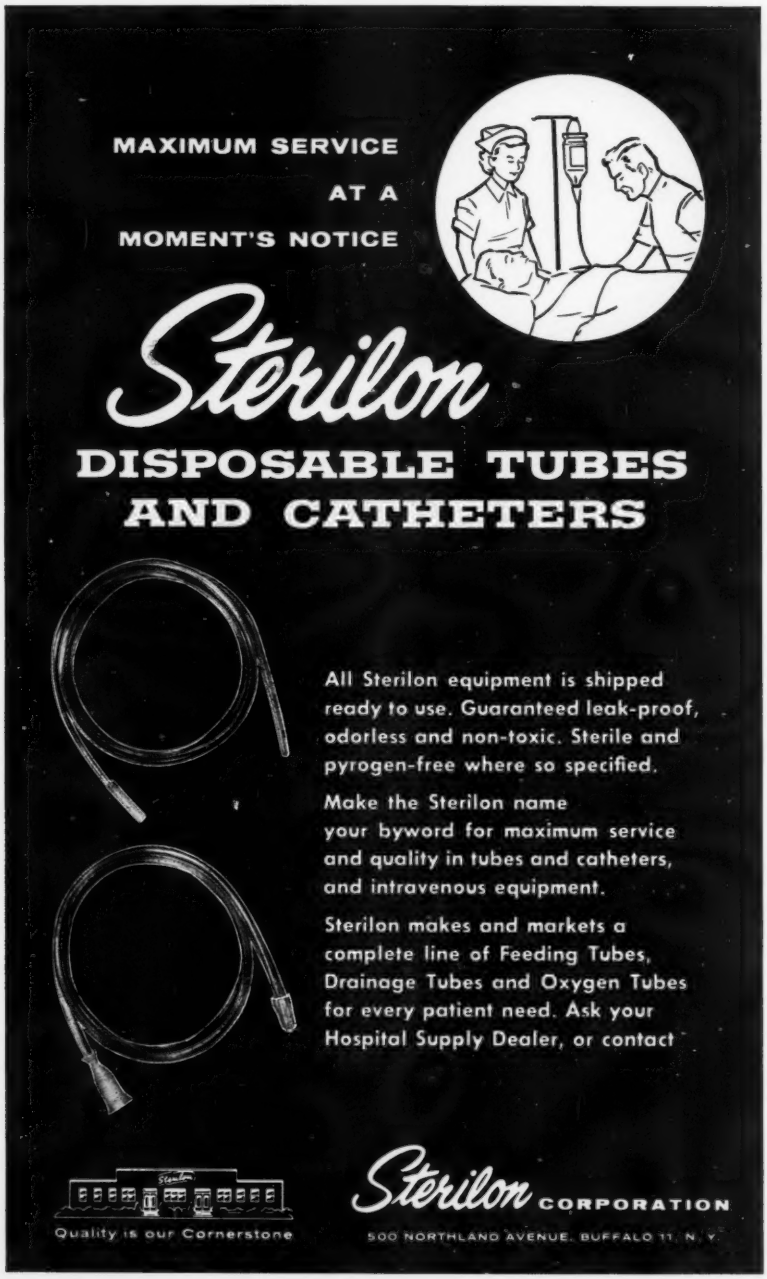
June 1-4—Catholic Hospital Association, Kiel Auditorium, St. Louis

August 24-27—American Hospital Association, The Coliseum, New York City

August 30-September 4—Second World Conference on Medical Education, Palmer House, Chicago

October 26-28—Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D.C.

October 26-28—National Rehabilitation Association, Boston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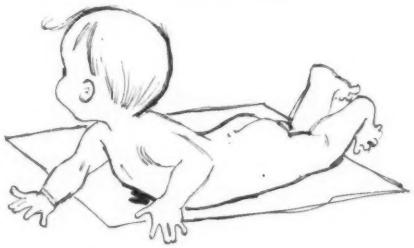

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*Reported in Hospitals, Journal of the American Hospital Association, Aug. 16, 1957.

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AHA 60th annual convention · Part II

• In this section HOSPITAL TOPICS concludes its report on the highlights of the 1958 AHA convention, held in Chicago, August 18-21. Part I of this report appeared in the September issue, pages 17-32, and a special tour of the technical exhibits appeared in that issue, pages 81-87. Additional technical exhibit coverage starts on page 67 of this issue.

The Patient and The Press

Hospital Must Serve as Liaison Between Patients and News Media

The illness of certain citizens is not "illegal," yet the hospitalization of well-known personages often gets into the public domain, so to speak. Legal problems, in this and other patient-press situations, are not the ones the hospital administrator is likely to face; more critical is the invasion of privacy, which has various interpretations under the law, and in the mind of the public.

Hospitals and doctors may be liable for suit for slander for oral remarks; for libel for comments expressed in writing. In one case, a physician was sued by a patient because she was given the diagnosis—venereal disease—in the presence of two members of her family. The court held no liability was involved, since the case inevitably concerned the well-being of the family as a unit. Yet when *Time* magazine published a picture of a pancreas patient with an insatiable appetite over the caption "She eats for 10," the publication was held liable.

Almost all cases of successful suits brought by patients involve photographs distastefully handled. If one will make it a basic rule to supervise photography, he will find the press cooperative and the hospital's legal security unimpaired.

Disaster cases, of course, come in the category of news matter of public interest, and the press is entitled to cover such cases, provided patient care is not impeded nor good taste offended.—*James E. Ludlam,* Los Angeles, legal counsel, California Hospital Association.

Reporter Points to Need for Clearly Defined Channels of Authority

From the viewpoint of a working member of the press, it would seem that the privacy of the patient is sometimes confused with the privacy of the hospital and the privacy of the press.

Let me cite an example. The public relations head of a private New York hospital called a newspaper to discuss the possibility of a human interest story concerning an indigent patient being cared for in the hospital.

The public relations department cleared the story with the authorities, and reporters spent several hours interviewing those concerned. The story was killed when the medical director phoned to state that the hospital motivation angle could not be used; he was alarmed over the number of calls he might receive from indigent patients or their relatives.

Both sides of this impasse are understandable; yet, if channels of authority had been clearly defined, and observed, it would not have happened. Reporters resent being intentionally misled or put off, of course, but it is equally wasteful of time and good public relations to mislead them through a misunderstanding or bogging down of channels.

The privacy of a ward patient is entitled to as much consideration as that of a paying patient who says he doesn't want any publicity.—*Emma Harrison,* health and welfare reporter, *The New York Times,* New York City.

Discussion

Q. What are the legal implications of the release form?

MR. LUDLAM: In some states such a form is a legal requirement; therefore, it is advisable in all states to make it a self-imposed requirement to avoid possible complications. The patient should have the approval of his physician before making any statement. It will give him a feeling of security, and help relieve his mind of any doubts.

Q. Do newspapers rely on the hospital to secure such releases?

MISS HARRISON: Yes. We consider it part of the function of the hospital, since it is in contact with the patient, his family and physician, and much better advised in the case than we can be.

Q. What happens when the patient is not physically or mentally fit to authorize such a release?

MISS HARRISON: A newspaper would not want a story from such a patient, unless it is an emergency case, in which situation it becomes a matter of public recognition.

Q. Are the rights of noncitizens the same as those of citizens?

MR. LUDLAM: Yes. We think in terms of the rights of individuals.

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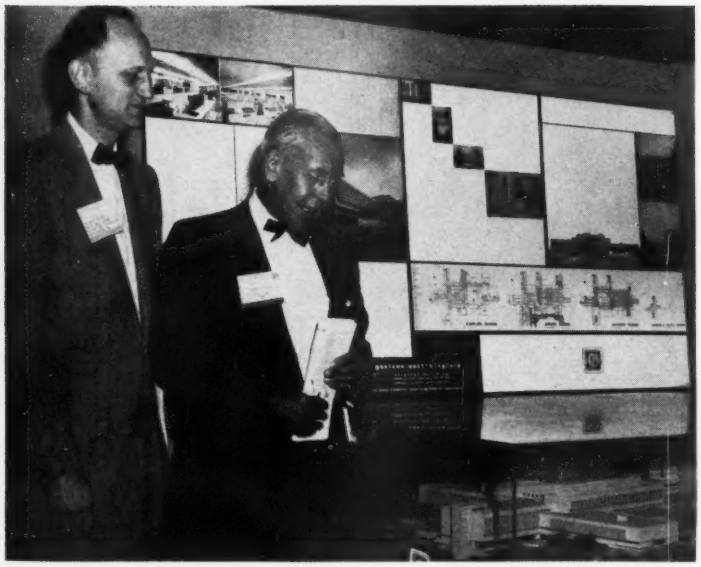

Left: Hugh H. Hussey, M.D. (l.), dean, Georgetown University School of Medicine, Washington, D.C., and Frank R. Bradley, M.D., director, Barnes Hospital, St. Louis, and past president, AHA, discuss new hospital designs at convention architectural exhibit.

Below: Mrs. William Groat (l.), Women's Auxiliary, Booth Memorial Hospital, New York City, emphasizes a point to Col. Florence Turkington, director of Eastern Territory Salvation Army Hospitals, New York City.

AHA continued

Money, Staff Inadequate

Project Analyzes Problems of Agencies Dealing with Planning, Licensing Laws

Principal administrative problems of state agencies concerned with operation of hospital planning and license laws are related to inadequacies of money and staff, we found in research study W-42.

The following deficiencies were noted: Definitions were poor; licensing agencies often did not have sufficient authority; delegation to local agencies is difficult; licensing programs, for both nursing homes and hospitals, concentrate on physical facilities and not on personnel standards; some states limit licensure to hospitals constructed under the Hill-Burton program.

The functions of licensing agencies in states may be summarized as writing and revising regulations, inspecting facilities, issuing licenses, policing for conformance with standards, and providing consultative services.

There is general agreement among government and nongovernment persons and agencies that licensing agencies should have a broad role. However, 58 percent of nongovernment and 83 percent of government persons and agencies believed that hospital licensing staffs were inadequate. Sixty-eight percent of nongovernment and 86 percent of government persons said nursing-home licensing staffs were inadequate.

Generally, licensing agencies are not equipped to assume a major role in planning and in conducting institutes and other training programs. There is a particular need for training programs for nursing-home operators and personnel.

Nongovernment persons and agencies look to the state agencies operating the Hill-Burton program to assume a broader responsibility in community planning for hospitals. Generally the quality and quantity of personnel administering state Hill-Burton programs is poor, as contrasted with the high quality of personnel in the regional offices of the Public Health Service.

The number of personnel in state agencies varies substantially. In one state that has received approximately $20 million since the inception of the program, there is a staff of 14 persons. In another state which has received the same amount, there is a staff of only two.—*Hilary Fry, Ph.D.*, Santa Barbara, Calif., former project director, W-42, and *Alan E. Treloar, Ph.D.*, director, Hospital Research and Educational Trust, Chicago.

Tools Not Enough

Administrators Have New Tools Now They Must Learn to Use Them

Administrative practices have not kept pace with our increased knowledge and concepts—our awesome array of new tools.

Why not? Because we're dependent on tools. We expect them to do the work, and forget that administration is an art as well as a science. Take communication, for instance. It's important, it saves time, and we tend to judge ourselves by how good our communication system is. But the system can never be as important as what's being communicated. Employee attitudes can be said to be dependent on communications. Are they any better than they used to be? It seems to me that there has been no marked improvement in the past several decades.

What are the justifications for administration in the first place? The most basic one, probably, concerns human behavior. Our purpose is to modify human behavior by influencing it to become the sort that is good for the entire organization. By examining and manipulating causes, we interfere with

what would happen without administration and lead the behavior into beneficial channels.

Naturally, restrictions are placed upon us in our efforts. There are moral restrictions, which inhibit us from exerting as forceful an influence as we might personally feel is called for. There are legal restrictions, because we must work with organized interest groups. And there are economic restrictions, because we face a scarcity (and therefore a limited selection) of human resources.

There are the restrictions placed upon us by society. Those of us in the field know that hospitals are big business, and must be run as realistically as are other big businesses. But to the general public, hospitals are not "in business." Some of our potential efficiency in cutting costs must be restrained because it would also cut down on public interest.

But even within the limitations of our functions, we can do these things: serve as the representative of the hospital, making it articulate inside and outside of itself; give direction, by making choices and decisions, and having realistic reasons why given activities will benefit the whole; organize and arrange —relate people and things together and deploy resources—toward desired behavior; combine technical and political skill by knowing what technics are being developed and persuading to acceptance of new ideas; utilize speculative skills by putting two and two together to anticipate results of behavior.

The administrator needs a sense of restlessness, because change for the sake of change is good, inasmuch as it represents activity; a sense of incompleteness, which makes it impossible for him to see a job as "wrapped up"; a sense of appropriateness, or tact; a sense of skepticism, which is an unwillingness to take things, especially conflicting stories, at face value; a sense of detachment, which is the ability to pace oneself emotionally, to remove oneself from a problem and see it objectively.

If an administrator does not feel adequate, the staff senses it, and their awareness will be reflected in their behavior. More tough-mindedness is needed so that the organization can spot exactly where the administration stands.

Olive M. Murphy, R.N., administrator, Bartholomew County Hospital, Columbus, Ind., chats before banquet with members of her hospital's board of trustees who made the trip to Chicago especially to attend with her the sessions on Wednesday, designated Trustee Day at the meeting. Trustees, from left, are: William G. Fish, Carr Lentz, Lynn N. Stewart, and Herschel E. Murphy, all of Columbus.

Timing is extremely important in putting across desires and ideas. One must create a climate in which personnel will be free with ideas without fear of punishment.—*Ray E. Brown,* superintendent, University of Chicago Clinics.

Balancing Act

Purchasing Agent Must Use, Not Be Used By, New Products

Expanded industrial research has brought us a fabulous assortment of new products. But we cannot afford to be swept off our feet by existing new products or potential ones. Before any new product is accepted as part of our hospital inventory, it must meet these "six essentials":

—*Safety.* It must pass, with flying colors, every safety test it will encounter in actual use; our requirements are especially rigid for electrical equipment.

—*Satisfaction.* It must possess specifications proved essential for the job it must perform.

—*Speed.* It must cut handling time.

—*Service.* It must be certainly and quickly available.

—*Savings.* It must represent a savings in man hours and/or original expenditure and upkeep.

—*Space.* It must fit a predetermined space. Few hospitals have room for white elephants, however attractive they may be at first glance.—*Charles E. Burbridge,* superintendent, Freedmen's Hospital, Washington, D. C.

Sharing Skilled Workers

Traveling Medical Record Supervisor Proves Effective in Minnesota

A record librarian is just as essential in a small hospital as in a large one, but the feeling of need decreases (in both parties) with size—which usually also means the size of financial resources.

In Minnesota, our answer to the problem has been group supervision in medical record-keeping. A pioneer in the field is Katherine Langer, who in 1956 gave up a full-time job to travel a 150-mile circuit, spending a week or two setting up a record system, and subsequently devoting a day or two to training and supervising workers at the various hospitals.

Others have followed her lead, and the sum total of their experience indicates that the effectiveness of such a traveling supervisor lies in her honest appraisal of the duties of clerks and stenographers. More important, perhaps, is her honest evaluation of their potentialities. It has been shown that high school graduates, given meticulous on-the-job training, turn in consistently creditable performances. The supervisor, in turn, receives a far greater measure of job satisfaction than she would if she confined her experience and efforts to one small hospital.—*Sister Loretta,* chief medical record librarian, St. Mary's Hospital, Duluth, Minn.

(Continued on next page)

Informal gathering between sessions brings together (from left): Nathan Bushnell, III, administrator, Franklin Memorial Hospital, Rocky Mount, Va.; Charles T. Wood, assistant director, Massachusetts Eye and Ear Infirmary, Boston; William R. Reid, administrator, Jefferson Hospital, Roanoke, Va.; and W. C. Bloxom, administrator, Johnston-Willis Hospital, Richmond, Va. Mr. Reid is secretary, and Mr. Bloxom, president-elect, Virginia Hospital Association.

Rural Rehabilitation

Program Aimed at Helping Handicapped Become Self-Supporting

Our small community hospital serves a rural area within a 175-mile radius in Kansas. When we started planning for a multi-disability rehabilitation center seven years ago, there was no pattern for such a program suited to rural areas.

The community had adequate acute beds, but no facilities for the chronically ill or patients with traumatic disabilities. Because there were no rehabilitation centers in Kansas, people were forced to go out of the state for treatment in such facilities.

Our center is situated in a new wing designed for this service and attached to the general hospital in order to utilize diagnostic services. It has four stories with 76 beds, 17 of which will be psychiatric beds. We have a physiatrist, speech counselor, social worker, chaplain, occupational and vocational therapists, and nurses geared to outside living. We are fortunate in having personnel who want to stay in West Kansas.

We have gym modalities and facilities for outside living, as well as facilities for psychological and vocational testing. The industrial arts department of our state college is working with us in vocational rehabilitation.

There are no private rooms, because we feel that rehabilitation should not be an isolated process. Self-help is emphasized, and each floor has a large dining-room and day room.

In many ways the program is experimental. This is a specific attempt to meet the needs of the handicapped to have lives of dignity, not stagnation or negation. It is hoped that these people will become self-supporting. Older people may not be productive, but they will learn to take care of themselves. The rehabilitation approach must be humane and economical; it is better to put these people back to work than to keep them on the welfare rolls.

We know the general needs of our population, but not specific cases. It will be years before we have full utilization of our unit, and we are budgeting for a deficit for three years.—*Austin J. Evans,* administrator, Hadley Memorial Hospital, Hays, Kans.

Two-Year Program

Warns of Possible Difficulties In Experimental Program

The associate degree (two-year) program is an entirely different approach to nursing education. It is not the first two years of a three-year program, nor is it the first two years of a four-year baccalaureate program.

It is not a less expensive program. All available evidence indicates that it costs approximately the same amount to operate a two-year program as it does to operate a three-year program. Some costs are reduced, but others are increased.

It is very difficult to get competent teachers. Since most nurses are graduates of hospital schools, you must ask graduates of one type of program (the three-year hospital school) to change their methods and teach in a different manner.

The three-year program is the backbone of nursing education. Hospitals should not jeopardize good programs because they hear there is something new going on in nursing education. Of course, if something is wrong with their programs, it might be worthwhile for them to consider the two-year program. But if they want to experiment, they should be ready to stand the strain and pain and expense of doing something new.

There are 36 programs of this type in existence now. Most of them are in public institutions. The cost to the hospital is practically nothing, because all the hospital is doing is offering its facilities as a laboratory for the class. Of course, there is some

Lauretta Paul, executive director, Community Hospital, Almont, Mich., learns details of the Manchester (Conn.) Memorial Hospital pilot study in progressive patient care from Manchester administrator, Edward J. Thoms. Results of the research, conducted during the past year under a Hill-Burton grant, will be published in January by the U.S. PHS.

cost, because the necessary planning and co-ordinating take time. Cost to the student ranges from the regular tuition for a private institution to nothing for a public institution.—*Robert E. Kinsinger,* consultant, associate degree programs, National League for Nursing, New York City.

U.S. PHS members talking after federal hospital executives' luncheon are (from left): Edward H. Terry, administrative director, PHS Indian Hospitals, Washington, D.C.; Edgar N. Duncan, chief, pharmacy service, PHS Hospital, Chicago; and D. W. McNaughton, M.D., deputy assistant chief for hospitals, PHS Division of Indian Health, Washington, D.C.

To Remodel or Not

Long-Range Building Plan Needed Before Remodeling Is Started

If a building is 50 or more years old, in most instances it is as economical to build a new building as it is to convert the old one to a modern facility. An old building always has major mechanical deficiencies that must be overcome, such as inadequate power supply and water lines, and waste pipes that are too small. There is usually an inadequate number of wash basins and toilets.

The decision must be made whether to replace the old building, remodel it, or convert it to secondary use, such as living quarters for personnel or storage.

Remodeling should not be undertaken until a complete, long-range building plan is well thought through and developed. This "master plan" should include a sequence or priority for work.

Good planning can best be achieved by use of study groups. The administrator in effect is the generalist trained to co-ordinate the ideas of many specialists. He should be the co-ordinator for the study groups and the liaison person with the architect. The steps in effective planning are:

1. Identify the role of the hospital in the community.

2. Determine the manpower, space, and equipment requirements necessary to meet the hospital's objectives.

3. Make an architectural and engineering review of the entire plant.

4. Develop a long-range or "master plan" with identification of possible steps with "price tags."

5. From this master plan, decide whether to replace or to remodel.—*Jacque B. Norman,* hospital consultant, Greenville, S.C.; *George W. Graham, M.D.,* director, Ellis Hospital, Schenectady, N.Y.; *G. O. Lindgren,* administrator, Trinity Lutheran Hospital, Kansas City, Mo.; *James J. Souder, A.I.A.,* Kiff, Colean, Voss & Souder, architects, New York City; and *E. Todd Wheeler, F.A.I.A.,* director of hospital planning, E. Todd Wheeler and Perkins and Will, architects, Chicago.

Progressive Care

Patients Well Satisfied with Program, Manchester Administrator Reports

Progressive patient care is the systematic classification of patients according to their individual needs. We have four main divisions now at Manchester (Conn.) Hospital:

(1) Special care unit, for patients who are critically ill; (2) intermediate care unit; (3) self-service unit, for ambulatory patients or those who need a complicated workup; (4) continuing care unit, for patients who require medical and nursing care every day, and probably will require 30 or more days of hospitalization.

Patients can be admitted into any stage of the program. Good physician-hospital teamwork is essential, since the physician is primarily responsible for the movement of his patients to different units.

Our hospital has 187 beds and 30 bassinets. When we subtract the obstetrical and pediatric beds (which are not included in the progressive-care program), that leaves 135 medical and surgical beds. Of these, there are 27 beds in the special-care unit, 17 of which are super-critical. The intermediate unit has 90 to 95 beds. The self-service unit is in a house across the street, which we converted. We started with eight beds, and now have 11 semiprivate beds.

Patient satisfaction is beyond our expectation, especially in the self-service unit. Our over-all length of stay has dropped from 6.6 to 5.9 days in a year.

We do not use our special-care unit as a terminal unit.—*Edward J. Thoms,* administrator, Manchester (Conn.) Memorial Hospital.

PHS Plans Studies on Bed Allocation, Nursing Standards, Nurse Supervisor's Role in Program

The major criterion for judging the progressive-care program should be the effect it has on patient care. Patients have been the greatest supporters of this program.

There is no evidence yet to indicate whether the program will cost more or less. To us in the Public Health Service, this is secondary. The major studies which we plan to undertake this fall are on principles of bed allocation in the various units, determination of minimum and optimum nursing standards, and the role of the nurse supervisor and the head nurse in the program.—*Faye G. Abdellah, Ph.D.,* chief, nursing education branch, Division of Nursing Resources, U.S. PHS, Washington, D.C.

HOSPITAL Topics reports on . . .

American Congress of Physical Medicine and Rehabilitation

Therapist Can Help Patient Deal With Traits Blocking Rehabilitation

Patient Can Be Directed Toward Immediate Goal, Asked to Concentrate on It

Many handicapped persons have characteristic ways of reacting to stress which the doctor must come to understand fully and prescribe for accordingly. These stress reactions may build up in the patient while he is learning a prescribed rehabilitation task, and he may have no control over them.

Therapists may get the feeling that the patient really doesn't want to get well, and come to resent his reactions in the presence of repeated failures and stop trying to find new and better ways to help him struggle with his problem.

The patient can be helped in several ways: (1) by assurance from the therapist on the case that he or she knows that the patient by himself cannot prevent the personality trait from taking hold; (2) by direction of the patient toward an immediate goal, such as strengthening a certain muscle or taking a certain movement, rather than toward the ultimate goal of as much rehabilitation as possible; (3) by a request that the patient consciously concentrate on the goal at hand despite the interfering personality trait.—*Manuel D. Zane, M.D.*, assistant clinical professor of psychiatry, New York University College of Medicine, New York City.

Rehabilitation of Handicapped Called Tool For Penetrating Iron or Bamboo Curtain

Advocates International Health Institute For United Attack on Disease, Disability

There is a growing recognition here that rehabilitation of the physically handicapped can be a remarkably effective tool which can penetrate any Iron or Bamboo Curtain.

We must meet the challenge presented by the increase in the number of physicians graduated by Russian medical schools. It has been reported that there are more doctors than can be absorbed in Russian health services, and physicians are being used for jobs we ordinarily assign to nurses and technicians. If the production continues and the excess increases, obviously the physicians will carry the skills they have learned, along with the concepts of communism, to the backward parts of the world.

We can meet the challenge, for our physicians are better trained. By using total professional personnel, therapists, sanitary engineers, public health administrators, and educators, we can do a better job.

The Institute of International Health, recently proposed by Sen. Lister Hill, would not replace any current programs of multilateral international health activities through WHO or UNICEF but would provide a mechanism and funds for uniting the sciences of the world in a greatly expanded global attack on disease and disability. Rehabilitation is one of the major scientific and clinical fields in which research would be conducted.

Senator Hill's new Health for Peace plan is directed toward a battle for inner space—the inner space in the minds and hearts of mankind. We in physical medicine and rehabilitation have both a responsibility and an opportunity to play a major role in this, the most important of all battles.—*Howard A. Rusk, M.D.*, chairman, department of physical medicine and rehabilitation, New York University-Bellevue Medical Center, New York City.

Oral Positive-Pressure Breathing Gives Post-Polio Patients More Freedom

Patients Requiring Controlled Ventilation Can Stand, Walk, Ride in Car

Oral intermittent positive-pressure breathing has proved helpful for 34 out of 53 convalescent polio patients in need of mechanically controlled ventilation.

Filtered air is intermittently pumped to the patient's mouth through a hose and pipe-stem mouthpiece which can be grasped in the teeth and released or held as desired.

Advantages for the patient over conventional methods include self-regulation of tidal volume, partial self-regulation of rate, improved accessibility for nursing care, freedom from shell and tank encumbrances, less hindrance to standing and walking, and preservation of rib-cage mobility through maintenance of normal respiratory excursions. Thus, the method has proved useful for both artificial respiration and physical therapy.

It can be applied even in an automobile. A pump furnishes pressure either through the car's electrical system or from batteries.

Proper training is necessary to use the method. Eating is difficult, and dryness of the mouth occurs. Like other positive-pressure methods, this one may cause elevation in the patient's blood pressure. However, circulatory changes are minimal under certain circumstances.

(Continued on page 92)

New York Health Show Draws 50,000 Viewers

• Over 50,000 moppets, teenagers, and adults paid 25 cents each to see the New York City Health Show, the first citywide report of public health progress in 20 years. A health education project of the New York City Health Department, which was sparked by Leona Baumgartner, M.D., City Health Commissioner, the show featured the work of more than 80 health organizations.

Held in the Coliseum, August 6 through 23, the show was designed to tell the public about the various aspects of health—where to go and what to do to achieve better health. Highlighted were some of the outstanding public health advances during the past two decades, including protection against polio, diphtheria, and other childhood diseases; education about vaccines, hygiene, diet, cleanliness, weight control, and protective measures; progress in coping with cancer, and means of awakening the public to taking proper precautionary measures.

Exciting highlights of the show were "the cow of the future," a mechanical heifer put together by the Metropolitan Dairy Institute to illustrate dairy protection measures; a 3-dimensional, dome-like plastic model of a human cell enlarged one million times; and Renee Mary Ann Rama-Santo, smallest baby known to survive in New York City in the past 10 years. Renee, who weighed one pound, five ounces at her premature birth, celebrated her first birthday at the show, where she displayed a lively spirit and two teeth in a spontaneous grin.

Successfully established, the show will become a regular feature of New York's Summer Festival.

A map, displayed at the exhibit, showing the locations of 34 maternity homes and hospitals, and three general hospitals, which the Salvation Army operates in the U.S., helps Col. Florence Turkington, Women's Social Service Secretary of the 11-state eastern territory, discuss the organization's role in the hospital field with Morey R. Fields, M.D., director, bureau of public health education, New York City Department of Health.

Irving Starin, M.D. (l.), Bronx Borough director of health services; Beulah Gutenstein, senior public health educator, New York City Department of Health; and Phil Michaels, president, South Bronx Community Council, are shown a wood carving from a Day Center for Older Persons by Lena DeGrazia, president, William Hudson Center, and Sam Schweiger.

Below: Free balloons and a brief talk in easy-to-understand language, are given a group of youngsters by members of the National Multiple Sclerosis Society.

NATIONAL MULTIPLE SCLEROSIS SOCIETY
NATIONAL MULTIPLE SCLEROSIS SOCIETY NATIONAL HEADQUARTERS, NEW YORK
"I Never Dreamed It Could Happen to Me"
MS
Hope Chest

Are Hospital

● The House of Delegates of the American Hospital Association, meeting in Chicago last month, took strong action to aid hospital schools of nursing: It called for the establishment of an independent joint commission on accreditation of hospital schools. Delegates made it plain that hospitals were dissatisfied with the present accreditation program of the National League for Nursing (see the September issue, pages 19-21).

Just after the resolution received unanimous approval, HOSPITAL TOPICS asked some of the persons who had been most vocal during the lively House session—including Thomas Hale, Jr., M.D., who was responsible for the amendment which strengthened the resolution—to record their views in the panel discussion which follows. The moderator is Alice R. Clarke, R.N., editorial consultant, who, as the editor of *R.N.*, a Journal for Nurses, was well known for her outspoken, independent editorials.

Participants:

Dana Hudson, R.N., director of nursing, Georgia Baptist Hospital, Atlanta.

Thomas E. Frey, administrator, Allen Memorial Hospital, Waterloo, Iowa.

Donald W. Cordes, administrator, Iowa Methodist Hospital, Des Moines.

Kenneth E. Knapp, administrator, Thomas D. Dee Memorial Hospital, Ogden, Utah.

Thomas Hale, Jr., M.D., director, Albany (N.Y.) Hospital.

"At the present time the policies of the NLN for accreditation are made by 21 persons . . . The hospitals have not had any voice in the policy-making concerning accreditation . . . If the NLN dateline is adhered to, it will mean that a great many schools will not be accredited."—DANA HUDSON.

MISS CLARKE: That there is genuine concern for the future of hospital schools of nursing was quite evident in the delegates' discussion today. What is the future of hospital schools? What would you identify as a threat to the hospital school program, Miss Hudson?

MISS HUDSON: The point I want to get over is that unless there is a deferment in the NLN's accreditation dateline, there will be many hospital schools that cannot be accredited because they do not have teaching personnel, and can't get faculty. The only way they can get them is to help their present staff prepare themselves. Yet, when these persons go off to school for further training, they are not interested in the hospital schools when they return. That's a very real problem.

Sometimes the hospital pays the expenses of these nurses to get their bachelor's and master's degrees. And when they get back, in a great many instances, they have turned against hospital schools.

If the NLN dateline is adhered to, it will mean that a great many schools will not be accredited. Someone has mentioned that half of our schools have provisional, and about the same number have full accreditation. Then there are 200 or more who either have been turned down completely or haven't asked for accreditation.

MR. FREY: The ratio is 40, 40, 20. Forty percent are fully accredited, 40 percent are provisionally accredited, and about 20 percent are not interested. If we don't have a date at which to shoot, there

Schools Doomed?

will be the danger that some schools will just not strive for accreditation.

MISS HUDSON: I don't believe that any school of nursing worthy of the name doesn't want to improve. Schools want to be improved.

MR. CORDES: I think the directors of nursing and the faculty would agree with you, but I think also that there are some situations in which the hospital administrator or the trustees feel there are lots of other things besides nursing schools which must be emphasized and on which they should also spend money. It takes money to improve the quality of a school, and I think Tom's got a point: Some kind of incentive is necessary—either the satisfaction of getting accredited or the threat that if you don't do it by such and such a time you're going to be closed. I believe there are some people who have been pretty dilatory about getting their schools approved.

MR. KNAPP: I'm inclined to think that Don is right in this matter. Education is not the primary function of the hospital. Taking care of the sick and the afflicted is the primary function. The administrator can very easily give his primary attention to the primary function. I sometimes think the educational phase of the hospital's operation, and thus the school of nursing, may suffer because of this.

MR. CORDES: There is one other point which I think is very real and not sufficiently emphasized in this discussion, and that is that hospitals are starting to do now what they should have done years ago—they are doing some honest-to-goodness cost accounting. There are all kinds of arguments as to what methods should be used, but nevertheless they are doing it. They are coming to realize what schools of nursing cost. Many people believe that the value of student services no longer equals the actual cash outlay of operating the school of nursing.

Now, suppose a hospital administrator makes that kind of study—and I have heard of several, some big ones—when he gets up against a difficult financial situation, he's human, he'll start to look at the place where his deficits are. If any of us had a bad operating-room situation, we'd look at the operating room and reduce the cost, or increase the charges. I think we're going to do the same thing about schools of nursing; this is one of the handicaps to getting schools of nursing approved.

MISS CLARKE: Do you think possibly there is a connection between the NLN's accreditation program and the motivation of hospitals to do cost accounting, especially in the nursing schools?

DR. HALE: I don't think there is a direct connection. I think it is inevitable that when a hospital school thinks about gaining accreditation it evaluates the necessary steps that must be taken, and then finds out that finances are involved. How much that discovery influences the hospital to go ahead with accreditation and try to make improvements is an individual matter. Each hospital's actions depend on how much it values its school, how much it wants to keep it going, how much it feels it is worth to the hospital, and how much it wants to spend in improving the school.

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"When we have sent faculty members to take extra work, some of them have returned and said that in the curriculum-planning class they have heard nothing about how to plan the curriculum of the three-year program—that all of the time has been devoted to the collegiate level. I believe this is alarming, and I certainly hope something will be done about it."—THOMAS E. FREY.

"I think the feeling of the hospital administrator is that the League people are in an ivory tower and are not really sensitive to the problems of the directors of nurses and the faculties in hospital schools."—DONALD W. CORDES.

HOSPITAL SCHOOLS continued

I think here we are talking about two different things as if they were one. One is Miss Hudson's feeling which she expressed, and in which I fully concur, that the average director of a school of nursing wants to improve her school. Her faculty wants to improve the school. And if they can't look forward to improvement, they are, first of all, going to be very unhappy, and finally are going to look elsewhere for jobs. That is, I am sure, a strong, impelling motive for all nurse educators.

Now, when we shift over and talk about hospital administrators wanting to improve their schools, we get some variations, I'm sure, with various administrators. Some of them think, "It's getting to cost too much—we'll drop the school." Others realize how important their school is, and look around for ways and means to finance it.

MISS CLARKE: Do you think the increasing cost of the three-year program has anything to do with the hospital administrators' interest in the two-year program?

DR. HALE: I feel that it is a very important factor. Many hospital administrators, faced with the increasing cost of operating a school of nursing, have been much more willing to consider dropping their school and letting a junior college assume the responsibility and the cost for nursing education. They feel then that the cost burden will have been removed from the hospital and nurses will be forthcoming for them without the expense and the problems of operating a school. I don't look with particular favor on this move myself, for it has definite disadvantages.

MISS CLARKE: Mr. Knapp, do you have a two-year or a three-year program?

MR. KNAPP: We formerly had a diploma program, and have surrendered that program for a two-year associate degree program. The motivation, however, was not cost. The thing that led us to make the move was the strong feeling that experimentation was in order in the training of nurses, and the feeling that our hospital schools were besieged with problems: faculty recruiting problems, primarily.

MISS CLARKE: Do you mean you couldn't get qualified faculty?

MR. KNAPP: Yes, we found ourselves following a course of expediency. When we were not able to secure the services of qualified people with degrees to take positions in our school, we didn't stop the class or stop the training; we put in faculty members on an acting basis who were not formally trained.

MISS CLARKE: Did you do anything about upgrading the faculty?

MR. KNAPP: We sought the services of our state universities to help us in this connection.

MISS CLARKE: Did you offer scholarships?

MR. KNAPP: Yes, we did, but the situation varies in different locales. We found in our particular locale that most of the people who were made available to us were married and had families, and were really not interested in leaving their home situation to go into special training, even if scholarship funds to do so were made available to them by a hospital.

MISS CLARKE: Did those who accepted scholarships return to your hospital?

MR. KNAPP: We provided scholarships in two instances when I went to the hospital in 1951. Both of these did return. One, however, left the nursing field because her husband was transferred to another area, and so we really had the services of only one from the two scholarships granted.

DR. HALE: Our hospital has made scholarships available to all nurses on the staff, including the faculty of the school of nursing, and we ask that they spend a certain amount of time with us.

MISS CLARKE: Do you specify the time?

DR. HALE: Yes, for so many credits they spend so

much time. However, that has not been a problem. A neighboring college opened a very excellent night-school course in our town about a year ago, and almost invariably all of the nurses get their post-graduate education at night school and continue working. Now it isn't a question of their going away for a length of time. It makes it very convenient for them and very fine for us.

MR. FREY: I am using some of the Ford money very satisfactorily. We have set aside $5,000 in an educational trust fund. We are using it for faculty people; we are using it for postgraduate work for staff nurses. But we have found that, just as Miss Hudson says, when we have sent faculty members to take some extra work, some of them have returned and said that in the curriculum-planning class they have heard nothing about how to plan the curriculum of the three-year program—that all of the time has been devoted to the collegiate level. I believe this is alarming, and I certainly hope something is done about it.

DR. HALE: I would back that up.

MISS CLARKE: Have you had students return to tell you that they have been told that they are wasting their time in going back to a hospital school; that they are perpetuating the hospital school; that they should be building up the collegiate faculties, not the hospital schools? Have any of you been told that?

MR. FREY: I haven't had that experience.

MISS HUDSON: I haven't had it personally on my staff, but one hospital I know of sent three different graduates away, paid their expenses and paid them their salaries while they were gone, only to find that when they came back their philosophy of nursing education had changed and they had turned against the hospital's program—were no longer effective in the school. They resigned and became affiliated with a university program.

MISS CLARKE: This is one thing I have heard from students.

MR. KNAPP: I think the appeal to the faculty member in leaving the hospital school and joining the college faculty lies in the feeling of prestige of being a member of the faculty of a university, and the feeling that she is associated with an institution whose primary interest is education. That is her primary interest; therefore, she feels a closer kinship with that type of operation. And possibly, she is accepted well in the college faculty program, whereas in the hospital group she feels a little on the outside of the main operation.

MR. CORDES: She shouldn't.

MR. KNAPP: Of course, the student does not have the same amount of clinical experience in the associate degree program. We are all aware of that. However, there is a degree of teaching at the patient's bedside with a clinical faculty member in charge of that teaching. We feel this is being done quite effectively.

MISS CLARKE: If the AHA forms a joint accrediting commission with representation from the NLN, the AMA, and other groups, do you think this will intensify efforts in upgrading the program in the hospital schools? Do you think there is a belief in some quarters that these programs have been neglected by the educators in favor of the collegiate programs; that the hospital school faculties haven't had the help they should have had from the educational groups in nursing?

MR. FREY: I would like to say just one thing. I am encouraged that the AMA will be invited to be represented on the proposed joint commission, because I believe there is a necessity for physicians' co-operation with students and with the faculties. I don't believe we are living up to certain philosophies in our teaching programs, especially in our smaller hospitals. I think the medical profession also needs help in its accrediting programs.

MR. CORDES: I think the feeling of the hospital administrator is that the League people are in an ivory tower and are not really sensitive to the problems of the directors of nurses and the faculties in hospital schools. Whenever you talk to hospital administrators, this comes out in various ways. When you talk to the League surveyors and to some of the educators making the policies, you find they've never been head nurses, and frequently have not been clinical instructors or directors of nurses or educational directors.

MISS CLARKE: Did you vote in favor of the AHA accreditation program?

MR. CORDES: I didn't. I voted this way; I voted that it should be thoroughly explored.

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"One weakness of the associate degree program is that the graduate has a more difficult time adjusting from the learning situation to the working situation . . . We have found, therefore, that lengthier orientation is necessary before we give her full responsibility in her assignment as a staff nurse."—KENNETH E. KNAPP.

MISS CLARKE: In the final vote, you voted for it, didn't you? The vote was unanimous.

MR. CORDES: Not that we initiate the program. That's what I asked on the floor: "Are we voting to initiate the program or are we voting that it be thoroughly explored?" The wording to me seemed to say that we should initiate the program.

MISS CLARKE: No, I believe it was worded so that it was to request the NLN, and AMA to join. But what was the purpose behind the proposal for a joint commission? Why did you want to request it?

MR. CORDES: To get more of the practical hospital viewpoint into the policies of the accreditation program.

MISS HUDSON: At the present time the policies of the NLN for accreditation are made by 21 persons. It has been very plain that anything the member agencies voted could be changed by the steering committee of five persons, and if they did not change it, then the board of directors could change it. Up to the present time, the hospitals have not had any voice in the policy-making concerning accreditation. We reviewed the criteria, but the steering committee refused to accept suggested changes at the 1957 NLN convention.

Alice Clarke's skill in guiding round-table discussions so that they would be thought-provoking and to-the-point was displayed many times during her years as editor of R.N., *a Journal for Nurses. Miss Clarke recently completed work for a master's degree at Columbia University.*

MR. KNAPP: I voted in favor of AHA's joining hands with these other groups to form a joint commission or at least to explore the possibilities of establishing a joint commission on accreditation of hospital schools of nursing, because I think we must recognize that hospitals are undoubtedly the largest single employer of the finished product of the nurse training program, and as such certainly must interest themselves in whether that finished product meets the actual needs of the hospital in its daily operation.

The hospital is in the best position to know whether the product is ill-prepared to fit into the hospital scheme of things as it exists in reality. The hospitals have such an important role to play in this program that we should concern ourselves with hospital-school accreditation standards. I feel this is true of the physician, too, who must rely so extensively upon the nurse members of his team. He, too, through his association in AMA, should have a part. I favor this very much.

MISS CLARKE: Do you favor the continuation of the hospital school?

MR. KNAPP: I definitely do. I am not one of those who think that because a new program has been introduced in the last five or six years, the old one should necessarily be condemned. I think there might be more than one effective way to train a good nurse. I would be very much opposed to the elimination of the hospital diploma program.

MISS CLARKE: Am I right in my understanding that one of the reasons for your going into a two-year program was that you could not get qualified faculty?

MR. KNAPP: This was one reason. A number of schools were having the same difficulties we were. We felt that some experimental work should be done. We were glad to become a part of that experimental program. Many fine things have come out of the associate degree program to help the general situation. I have never seen so much aggressive activity on the part of the hospital schools to do something about their problems as I have seen since the associate program has been introduced. I think this is good.

MISS CLARKE: How long have you had a two-year program?

MR. KNAPP: We were one of the original five pilot schools under the project of the Teacher's College, Columbia University. This is our sixth year.

MISS CLARKE: How many classes have been graduated?

MR. KNAPP: Four.

MISS CLARKE: Have you employed those nurses?

MR. KNAPP: Yes. We have never yet employed less than 70 per cent of the graduating class from this program since it started, and the figure has gone up as high as 94 per cent of our graduating class. This compares with approximately 30 percent employed under our diploma program.

MR. CORDES: That is a big argument in favor of it, of course. How does the quality of these students compare to that of graduates of the three-year hospital program?

MR. KNAPP: Very well. To begin with, the program left something to be desired. Since then, however, we have seen some marked improvements. The program is no longer the one we started with. The college has been very alert and progressive about following the recommendations of the advisory committee. The hospital has representation on the advisory committee; so have the physicians. The college has been sensitized to the feelings of the physicians and the hospital, and has been good about incorporating needed strengths and trying to correct apparent weaknesses. Now, I would put the graduate of our program on a par with the average diploma-school graduate in our own hospital.

MISS CLARKE: On a par—you do not find the two-year graduate superior?

MR. KNAPP: I think that one nas strengths in some areas which the other does not have, but there are strengths and weaknesses in both programs.

MISS CLARKE: Could you identify any of the weaknesses?

MR. KNAPP: One weakness of the associate degree program is that the graduate has a more difficult time adjusting from the learning situation to the working situation. This is understandable because she has not had as much clinical experience and is not as at home in the hospital. We have found, therefore, that lengthier orientation is necessary before we give her full responsibility in her assignment as a staff nurse. She is an eager learner, however, and shows a real desire to progress.

MISS CLARKE: Then your expectations are changed in employing a graduate of a two-year program. As an employer, you don't expect the same performance as you would from a three-year graduate. Is that correct?

MR. KNAPP: Well, I wouldn't endorse it the way you have said it. Yes, we do expect the same performance, but we find that the transition from the learning to the working situation takes longer. Orientation of the individual takes longer. The graduate is not as at home as the diploma-program graduate, or as familiar with the total hospital organization, or the manner in which all the departments in the hospital are interrelated.

MISS CLARKE: You think that she goes through an adjustment period.

MR. KNAPP: That's right. It is an adjustment on her part and the hospital's. I feel we have the responsibility to make it possible for this adjustment to be made effectively and smoothly so that she moves into her working situation with confidence.

MISS CLARKE: And the hospital is willing to do this?

MR. KNAPP: Yes. As a matter of fact, we now use the same orientation program for the graduates of the three-year schools who come to us. We find, however, that the orientation may not be necessary to the same extent for the three-year graduate as it is for the two-year graduate. We started with a six-week orientation. We found this was not adequate and extended it to a three-month period. Now we actually continue the orientation program for six months.

DR. HALE: Do the nurses work during this period?

MR. KNAPP: They work, but we do not let them work entirely independently. They are never given difficult assignments alone; they are under supervision. During the latter part of the six-month period the graduate is assuming full responsibility for her assignments, but the orientation continues because we want each graduate to have rotated and worked in all areas of the hospital, so that she can accept assignments in any one of these areas. This takes six months.

MISS CLARKE: So she is not really equated with the graduate nurse of a three-year diploma program from the time of employment? I go back to my original question. You have changed your expectations? When you hire a graduate of a two-year program, you are willing to make these adjustments?

MR. KNAPP: I answer "yes" to that.

DR. HALE: In a study we made in New York State, among the hospitals that have employed graduates of the two-year program (almost all of whom, I believe, are graduates of programs in and around New York State), we found that these hospitals felt that it took a minimum of three months or an average of three to six months (some said 12 months) before the graduate was able to assume the full responsibilities of a general staff nurse. This was the opinion of these hospital administrators, who consulted with their directors of nursing service. This confirms to some extent what you have just said.

We have been concerned in New York about the spread of the two-year program. Another study we did showed that a year ago, the schools of nursing in the state had attained in their entering classes only 67 percent of their capacity. They could have taken half again as many students without adding faculty or without adding to facilities. In view of this situation . . .

MISS CLARKE: All the schools?

DR. HALE: All the hospital schools in the state. It then became a matter of concern to us to see associate degree programs contemplated or opening in community colleges, because we felt, rightly or wrongly, that the girls that they would attract would mostly be girls who would otherwise have gone into hospital schools. We know that there are some, however, who would go into an associate degree program because the degree appeals to them, who would not enter nursing otherwise.

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"We feel that nursing is almost an all-or-nothing kind of discipline; that a girl who goes into nursing without having deeply inculcated in her a service ideal of taking care of her fellow man is not going to be a happy nurse, and certainly is not going to stay in nursing for as long a time, or be as good a nurse or be as interested in nursing, as one who is deeply inculcated with the idea of service. There, I think, is where we differ with certain nurse educators who do not believe that service should be any part of nursing education."—THOMAS HALE, JR.

"Hospitals are undoubtedly the largest single employer of the finished product of the nurse training program, and as such certainly must interest themselves in whether that finished product meets the actual needs of the hospital in its daily operation."

HOSPITAL SCHOOLS continued

All of our schools of nursing are having difficulty filling their faculty positions, so that every time a new school is opened it puts an additional drain on the faculties of the existing schools. There is prestige in a faculty appointment in an associate degree program; the pay is usually greater; and the life is easier insofar as the teaching program goes. The faculty members have longer vacations.

We were certainly concerned because we were not in complete agreement with the philosophy of education which the associate degree programs and the collegiate degree programs have. Now, I know it is a matter of opinion; that the nursing educators believe that they are doing exactly what is right.

But our concern is this—we feel that nursing is almost an all-or-nothing kind of discipline; that a girl who goes into nursing without having deeply inculcated in her a service ideal of taking care of her fellow man is not going to be a happy nurse, and certainly is not going to stay in nursing for as long a time, or be as good a nurse or be as interested in nursing, as one who is deeply inculcated with the idea of service.

There, I think, is where we differ with certain nurse educators who do not believe that service should be any part of nursing education. They believe that the students should watch and observe patients in the wards, but should have no responsibility for service in the hospital.

MISS CLARKE: Mr. Knapp, do you agree that the two-year school is producing a different type of nurse than the three-year diploma school when it comes to this particular subject?

MR. KNAPP: I think there is a difference in the two graduates.

MR. CORDES: You can say the same for the four-year program. The graduate of the four-year program is not the same nurse.

MISS CLARKE: But let us compare these two for now to see if . . .

MR. KNAPP: I would just like to say that my experience is undoubtedly not as broad as Dr. Hale's; it is perhaps more confined to our area and our situation. But I have not found a desire on the part of the nurse educators in this program to divorce service from education entirely. I agree that the clinical time on the floor has been reduced considerably. I think this is what you are referring to.

MISS CLARKE: Can you discuss your gradutes' "feelings" about nursing?

MR. KNAPP: We find that the two-year graduate's attitude is far superior to that of the graduate of the three-year diploma program. We have observed this very carefully, of course, because we are evaluating this program.

MISS CLARKE: Why do you get that feeling?

MR. KNAPP: The graduates have—for want of a better word, let me say—a "you" attitude which has been extremely refreshing to the administration at the hospital. They take a real interest in the patient and seem to be able to communicate with him far more effectively than could our graduates under the three-year program.

MISS CLARKE: You think the educational preparation they are getting in the two-year program helps them to do this?

MR. KNAPP: Something is doing this, and I attribute it in part, I believe, to the general attitude of the graduate to the hospital. I think that the graduate under the three-year diploma program has too often felt, rightly or wrongly, that she was being exploited. I think, rightly or wrongly, she has believed that the hospital was exercising complete control—not only educational control and work control—but parental control over her evenings, over everything she did. I think this feeling on the student's part has built some antipathy between the graduate and the hospital.

When a three-year graduate came into the hospital —and not as many of them did; I think I made that point clear—she came into the organization with a definite mind set. Time and again, she would sit down with our director of nursing service and say, "Well, I will work for the hospital, but these are the areas in which I will work, and these are the areas in which I will not take assignments, and these are the shifts I will work, and these are the shifts I won't work."

The graduate of the two-year school, almost without exception, has taken assignments wherever the director of nursing has assigned her. This has been of tremendous help, of course, in staffing our hospital. I say almost without exception, because we have had a few married girls in the program who felt they couldn't accept rotating employment.

MISS CLARKE: What reason do you believe is behind this different attitude of the two-year graduate?

MR. KNAPP: Well, I think the hospital to the two-year student is, should I say, a great big, wonderful laboratory, where she is having wonderful experiences, and where she just loves to come to do her clinical service. The other three-year student, who is at the hospital constantly and who too often, I believe, is used primarily as part of the labor force of the hospital, feels that so much that she does is not geared to her benefit, but she is doing it for the hospital, to get the hospital off the spot. The hospital

to her, therefore, when she accepts employment in it, is a place of less intrigue.

DR. HALE: Of course, it is only fair to point out that you are making a comparison between two specific schools, and these generalities might not apply elsewhere. I am sure that there are hospital schools today, and there have been some in the past, in which the morale was poor, in which the nursing school and the nursing service didn't work together, and the students were unhappy and didn't want any part of the hospital. But I don't think it needs to be that way at all. I have seen changes in personnel, such as the appointment of a new director of nursing service or a new director of the nursing school, which made the whole situation change from black to white. I don't think such problems are inherent in the system. I think they are a matter of personalities.

MISS CLARKE: Now let's see whether we can direct this to the point of the future of the three-year hospital schools. The resolution you passed today did not include the two-year college school.

DR. HALE: Well, at least, it will not when the program starts. There is no reason why this type of school can't be added if it is desirable on both sides.

MISS CLARKE: Do you foresee any difficulty in the future of continuing hospital schools under one type of accreditation?

DR. HALE: No, I don't see any difficulty at all. I think, as a matter of fact, that the action taken by the House will insure something which had been—in my mind, anyway—quite doubtful before. It will insure the continuation and eventual upgrading of the hospital schools of nursing.

MISS CLARKE: Do you think that this action will influence some of the hospital administrators who have been considering going into a two-year program because of the accrediting pressures?

DR. HALE: No, I wouldn't put it that way, because a hospital administrator can't ordinarily shift as a matter of volition from a hospital school to a two-year program. There has to be a two-year program planned and a college which is ready to set it up. I think that this action will encourage many hospital administrators who are about to give up their schools entirely to continue with them and hope that with added time, with help and support from their parent association, the AHA, they will be able eventually to meet reasonable accreditation standards and keep on producing nurses and rendering the service that they have in the past.

MISS CLARKE: There was a hospital administrator from North Dakota sitting beside Tom Frey and me at the House of Delegates session. He threw up his hands when the joint accreditation commission resolution was passed, and said, "I just gave up my school —I shouldn't have done it."

DR. HALE: I have talked to innumerable administrators in the last two years, who were so discouraged and felt so hopeless about being able to meet accreditation, with a deadline hanging over them, that they said, "What's the use? It's costing us more all the time, anyway. We could figure out some way or other to meet the cost if there was some hope of going on, but without accreditation, we will not get any students, because the high-school counselors are sending all their students to accredited schools only."

An administrator here has a letter in his pocket from a Navy nurse recruitment office saying in so many words that only graduates of fully accredited schools of nursing will be eligible for commissions.

MISS CLARKE: Do you think that the National League for Nursing will agree to a joint commission?

DR. HALE: I guess that they will.

MR. KNAPP: I would guess so, too, because I think that, in the last analysis, the objectives of the League and of our group are the same. I think that we want good training to prepare good nurses who will give good nursing care.

MISS CLARKE: Do you think the League will accept this resolution as an action to help them with this problem, not as a punitive action?

DR. HALE: I certainly hope so.

MR. KNAPP: I think this was a good action taken by the House today, and a needed action. I think it showed the widespread feeling that we all have about this problem. I hope there is no cause for concern about establishing, or at least recommending that we establish, a joint accrediting commission for hospital schools of nursing. I think it would be much better, however, if we could have a single accrediting commission for all schools of nursing. I would not like to see us embark on two standards or on a double standard of nurse training.

MISS CLARKE: Do you think that the three-year school and the two-year collegiate program can live side by side?

DR. HALE: I think that the division is not between the three-year and the two-year schools on one side versus the four-year collegiate program; I think it is between the hospital school on one side and both types of collegiate schools on the other. They are different in concept, philosophy, organization, and financing, and I think they should be different in accreditation.

MISS CLARKE: In considering the product that you are measuring—and you are measuring the educational system against the product—you're really trying to produce the same type of nurse by different means. Is that right? You're really going to employ both at the same staff level?

MR. KNAPP: Hospitals will probably not have enough applicants for staff positions to make a choice between the product of one educational program compared with another. At least, I don't think that's conceivable for many years, if ever. But you would make no choice if you thought the products were equal. Then you would not discriminate against one because of the system, if the product were right.

(Continued on next page)

DR. HALE: Right now, in our hospital, we start graduates of our three-year school of nursing at a higher rate of pay than we do graduates of collegiate schools, because they are worth more to us; they are better, they do not need any orientation period. It is a fair distinction.

MR. KNAPP: We don't do that. I feel that the two programs can live compatibly side by side. I think that the product of each program can be a good product. I think encouragement should be given to both programs.

DR. HALE: I believe that we need graduates of four-year collegiate schools of nursing, and that hospitals will be glad to employ them always, because they have a different kind of background. They should be, and I think are, better fitted, after maybe an orientation period, to assume higher responsibilities than the average graduate of the three-year school. I also think, however, that if all nurses went to a hospital school as a basic program and then received their advanced education afterwards, that would be a better means of starting them out correctly.

MISS CLARKE: Dr. Hale, do you still keep an open mind on the experimentation with the two-year program? Do you think it is something that should be continued? Do you think there might be a possibility in this type of education?

DR. HALE: If the hospital schools could produce enough nurses, I would see no need for a two-year program. If they can't, and it could be proved that the two-year programs would produce enough more acceptable nurses to fill the needs of the nation, then they might be given a try. I would rather see the emphasis put on strengthening the hospital schools.

MISS CLARKE: Do you think there is more optimism at this meeting that the hospital schools of nursing will continue?

DR. HALE: Yes. I'm sure they will always continue to produce the great majority of nurses that are required to meet the country's needs.

Ohio Hospital Nursing School Reaches Potential Students at State Fair

• The Holzer Hospital School of Nursing, Gallipolis, O., has found the Ohio State Fair, with its annual attendance of nearly 750,000, fertile ground for recruiting future student nurses.

Exhibiting for the third time at the Fair, held this year in Columbus, August 22 through 29, the school told its story in a display featuring enlarged colored, lighted photographs of the Holzer Hospital and Clinic and of the school's new nurses' dormitory and classroom. Sixteen moving, colored slides demonstrated activities inside both the hospital and dormitory. Two nurses were on duty at the exhibit to answer questions and give information.

Through use of this exhibit and its other promotional efforts, the school has increased its total enrollment to 83 students. A new high of 37 freshmen matriculated this fall for the 3-year training course. The school, in operation since 1920, hopes to have 100 students eventually.

One element which is attracting young women is the dormitory built two years ago, which combines classroom units with living quarters for 100 students. Other goals achieved by the school include improvement of quality of instruction, and affiliation with Rio Grande (O.) College for courses in the general science and social science fields.

Since the State Fair booth proved so effective, Holzer also exhibited last year at the International Plowing Contest in Peebles, O., which was attended by several thousand persons, including a large number of farm girls.

The school's year-round recruitment program includes talks by instructors and students in high schools, service clubs, and similar organizations, distribution of bulletins and brochures, and stimulation of interest in scholarships.

Julietta Pompa, clinical instructor, seated left, supplies the commentary as Sue Morgan, nursing school senior, runs the projector which shows attentive teenagers 16 color slides of interiors and activities of Holzer Hospital and its nurses' dormitory, at the school's exhibit at the Ohio State Fair.

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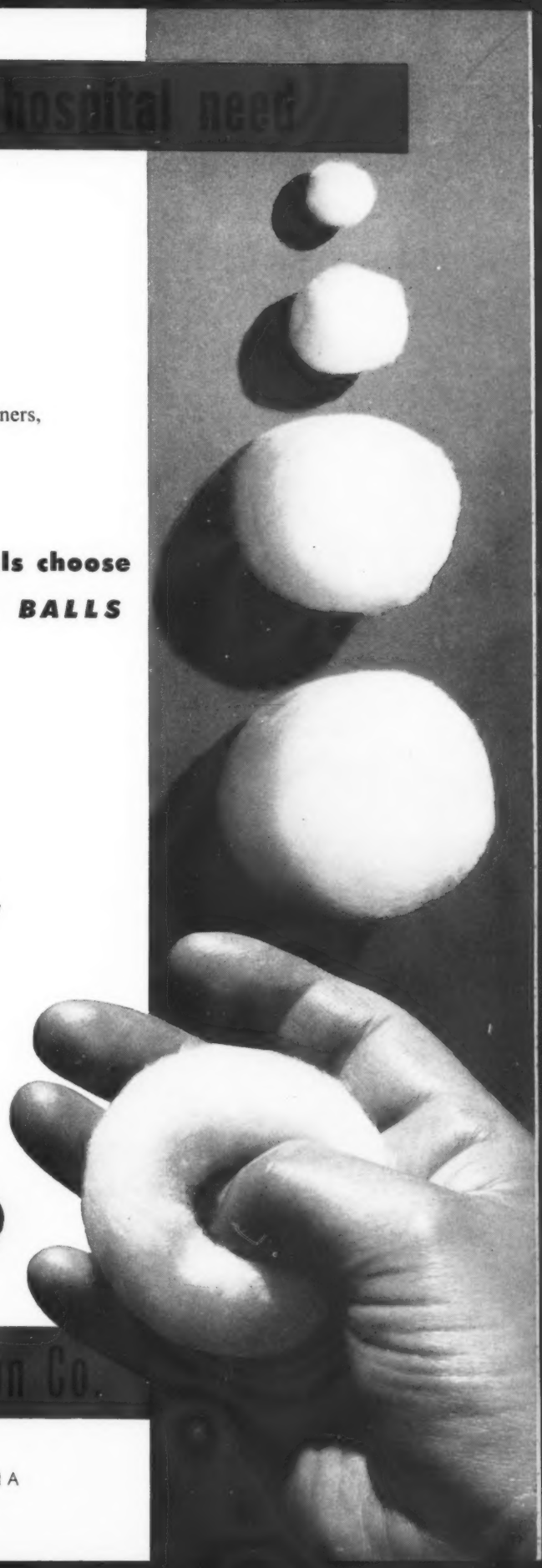

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Alcoholism: Its Nature and Treatment

By the Rev. John J. Lazarsky, O.M.I.*

Part I. Nature

• Although brought up in a good Catholic family and environment, Mr. X, early in life, began to write his own epitaph, of which he was partly proud and partly ashamed: Irish by birth; American by naturalization; Roman by upbringing; Scotch by absorption.

In the course of his life he was deleting the third line progressively, but, by the grace of God and the assistance of friends and others, having been dried out physically, mentally, and morally, he obliterated the last line and retained the third.

Alcoholism has been and is still considered solely or principally a vice, an allergy, or a disease. Before anyone could hope to discuss this phenomenon intelligently and label it correctly, he should know something about alcohol itself: its nature, properties, uses, and effects.

If alcohol possessed the qualities of milk or carbonated beverages, there would be no problem. But unfortunately, it has very definite physiological properties, which, when misused, produce directly disastrous physiological effects on the body and indirectly many other effects on the whole personality of the individual, and through him, still others on society. The problems of alcohol are many and complex: physiological, psychological, medical, legal, economic, moral, religious, and sociological. It is only reasonable and logical to consider the physiological action of alcohol on the body as a starting point.

There are hundreds of chemical compounds known as alcohol, of which the most popular are propyl, butyl, amyl (fusel), methyl (wood), and ethyl. Ethyl is present in all alcoholic beverages; it is the one we refer to when we speak of alcohol. All of the alcohols, because they are alcohols, have common properties—for instance, all are intoxicating if taken in sufficient amounts; and conversely, each kind of alcohol, because it is different from the others, has certain peculiarities which distinguish it from all the others.

Why have men chosen to use ethyl alcohol in preference to the others? Certainly not because of the properties common to all alcohols, but because of those qualities which are proper to it. Of all the alcohols, ethyl is the best suited and safest for human consumption; it is oxidized rapidly in the body; it is less toxic and less irritating; it has a more pleasant taste; it mixes readily with water; it is easily produced by fermentation.

When food is swallowed it is digested, but when alcohol is taken it is not digested but passes directly from the stomach and the small intestine into the blood stream, which carries it throughout the body. It is absorbed and diluted by all the fluids (intracellular and extracellular) of the body, and is consequently distributed equally throughout these liquids (the body consists of approximately 70 percent water). Oxidation begins as soon as the alcohol appears in the blood and continues as long as any part of it remains. During its presence in the circulating blood, alcohol produces its physiological effects on the body and psychological effects on the mind.

It is estimated that in the United States there are more than 100 million people of drinking age. Of these, 60 to 80 million use alcoholic beverages at least occasionally; and of these, seven million or more are said to be excessive drinkers (who are occasional drunkards); and of this group, four to five million are compulsive drinkers or alcoholics.

Excessive drinkers are persons who drink to such an extent that they risk the danger of becoming compulsive drinkers and even chronic alcoholics. Compulsive drinkers (alcohol addicts) are those who, although they wish to stop drinking, are irresistibly driven to it because they think (fear) that they cannot live without alcohol—an unconquerable fear that they cannot do without it drives them to it. Alcoholics are those who, in consequence of prolonged excessive drinking, have developed a pathological craving for alcohol, on the part of the body as well as on the part of the mind. Not necessarily, but most frequently, they arrive at this stage through compulsive drinking.

Naturally, those who do not drink do not expose themselves to the risk of becoming excessive drinkers, compulsive drinkers, and much less alcoholics, just as those who do not smoke will never become marijuana addicts. But abuse or misuse of a good or indifferent thing does not warrant the condemnation of its use.

(Continued on next page)

*Chaplain, Santa Rosa Hospital, San Antonio, Tex.

As far back as history can take us, we find that alcohol was used ceremonially in communal (tribal) rituals and religious rites. History also points to its use as a customary part of meals in some countries as well as for medicinal purposes. Although the sedative action of alcohol was soon discovered and utilized, in modern society most people fortunately use alcoholic beverages as condiments and refreshments, and for their social values rather than for conscious or unconscious sedation and relief. Alcohol is used somewhat regularly for its sedative values only by a certain type of drinker, and only occasionally by average users.

People drink alcoholic beverages for many reasons; they like them or they like something about them. Taste plays a very important role in our food and drink. Not every taste appeals to everyone; but it happens that some like the taste of alcoholic beverages, and even these people have their preferences. Others like to drink because drinking is the thing to do socially. Alcohol acts as a social lubricant, putting people at ease; it affords an opportunity for congenial companionship and a leisurely social visit; it is a traditional part of many social events and celebrations. People also use alcohol for its effects. It affords legitimate relaxation, giving some relief from tension, just as sleep, games, entertainment, and recreation do.

No doubt there are many who drink immoderately, either in the amount they take, or at the expense of others, or for wrong reasons. When people use alcohol for immoderate reasons they frequently proceed to use it in immoderate amounts, also. Such persons do not drink because they like alcohol, but because they do not like something else. They use alcohol as an escape and a crutch—an escape from physical discomfort, mental anxiety, shyness, lack of self-confidence, moral anxiety (guilt), problems, insecurity, boredom and loneliness; a crutch to bolster morale, to build up courage, to get the feeling of belonging, as among teenagers. An escape and a crutch go together.

Such drinking is dangerous because the thinking behind it is dangerous. These persons have a real dependence on alcohol which will not be cured by running to it. Although their drinking may be externally moderate, in due time it will become immoderate because their concomitant thinking is not moderate; while drinking they really do not drink but escape and puff up a false front of strength.

Our concern is not with moderate drinkers or drunkards, but with alcoholics. What is alcoholism? Is it a vice, an allergy, or a disease?

Alcoholism is a physical, psychical, moral, and spiritual sickness, by which the body, mind, and soul are diseased. It consists of pathological conditions in the body and mind and deterioration of the soul. It is an illness caused by the vice of intemperance of long standing, which may lose, in part or in whole, its moral qualification, especially in the later stages.

It is quite common for alcoholics to contract diseases—for instance, cirrhosis of the liver, Oriental beriberi, and pellagra—as a result of excessive drinking. Although these are diseases of alcoholism, they are not alcoholism as a disease. The latter consists of those physiological factors or a general disordered condition of the organism, conducive to abnormal drinking.

When we say that alcoholism is a sickness of the mind, we do not refer to that neurotic or psychotic condition that may be at the root of the alcoholic's trouble and which may drive him to drink, but to the addiction itself. This addiction or compulsive thinking regarding liquor takes possession of the alcoholic in such a way that he just cannot think of anything else at the moment. Nothing gets through to him, not even the strongest motives against drinking, which for someone else might be more than ample, even might be for him at some other time. When the compelling fascination for alcohol takes possession of his mind, it blocks the passage for all other thoughts for the present. His thinking processes are narrowed down to one thought, drink. And so alcoholism as a sickness of the mind is over and above other mental illnesses that may be the underlying causes driving the alcoholic to drink.

This compulsion does not impose itself on the mind of the alcoholic at all times, not even necessarily when he thinks of alcohol. It comes with greater or lesser frequency, with greater or lesser force, with greater or lesser persistence, even in the same individual. When it reaches a certain point it becomes pathological and is a compulsion in the strict sense of the term. Sometimes it lessens his freedom, and consequently

(Continued on page 50)

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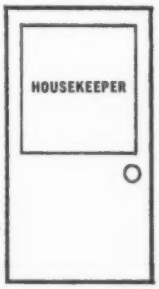

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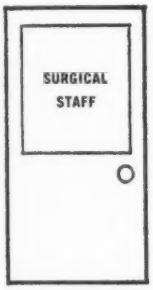

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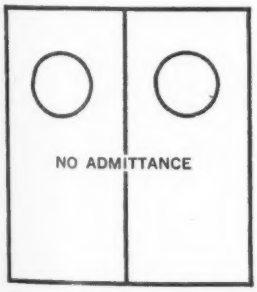

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TURN PAGE

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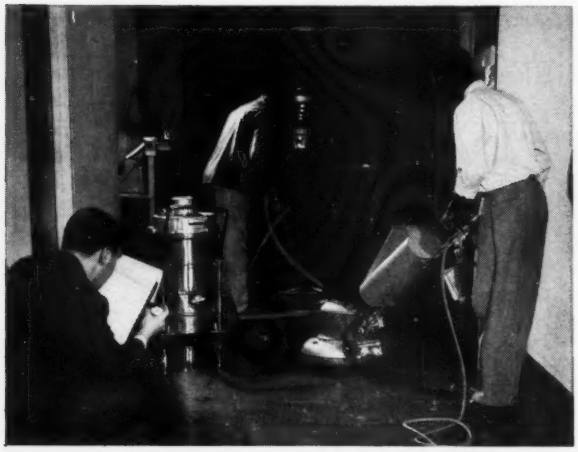

Comparative time studies of Tergisyl vs. conventional machine scrubbing vacuum pickup, and mop-and-pail application of disinfectant. One-step Tergisyl method reduced the man-time required by 22%. Actual time saved was approximately 23 minutes per 1,000 square feet of floor area—a labor saving of 20 man hours or 2½ man days each week in areas of heavy soil in a 300-bed hospital.

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Role of Housekeeping in Control Of Staphylococcal Infection

By Valerie Hurst, Ph.D.*

• Throughout history, infections acquired in hospitals have been a distressing problem. Although infections have been markedly diminished by improved sanitation, rigid application of aseptic and antiseptic practices, and the introduction of the antibiotics, those caused by staphylococci still remain unconquered. This is not due solely to the failure of staphylococci to yield to antibiotic therapy. It is due also to the failure of persons handling hospital patients and supplies to appreciate the sources of staphylococci and their routes of spread.

Pathogenic staphylococci can flourish on many surfaces of the patient's body, not only in the infected lesion, but also on the healthy skin and mucous membranes (Chart 1). They are abundantly distributed by the excretions originating from these sites. Consequently, the patient may contaminate everything with which his body has contact, particularly his bedding. Because staphylococci resist drying, they may remain alive and infectious on lint and dust particles for many months.

Chart 1
Sources of Pathogenic Staphylococci

Site	Staphylococci present in:
Infected lesion	Purulent or serous discharge
Skin	Epidermal scales
Nose, mouth, lung	Nasal and oral secretions; sputum
Intestine	Feces

The transmission pathways often are difficult to perceive because different individuals react variously to even the most infectious staphylococcus. What may cause only a trivial infection in one patient, may produce severe or even fatal infection in another (Chart 2). Some persons known as "carriers" fail to develop any clinical sign of infection despite luxurious growth of an infectious staphylococcus upon their skin and mucous membranes. Patients in this category may be particularly dangerous because, unlike those with obvious infection, they are not isolated and no particular precaution is observed in their management. Even more hazardous are those patients with infections considered too trivial to warrant isolation procedures.

Because of the characteristics of staphylococci, hospital housekeeping must be designed to minimize contamination of the patients' environment by bedding, lint, and dust. Procedures which require particular attention are described here.

*Assistant professor in microbiology, School of Dentistry and School of Medicine, University of California Medical Center, San Francisco. This article is based on a lecture presented at the 1958 convention of the Association of Western Hospitals, held April 21-24 in San Francisco.

Bedding and clothing must be handled with a minimum of agitation because they may readily liberate staphylococci into the air.[1] When soiled, they should be placed directly into a clean laundry bag and not deposited haphazardly on chairs or floor, or put directly into a laundry chute. Laundry bags must be securely tied because air drafts from the chute may return staphylococci to the corridor and patient areas.[2] Laundry carts which are used for the collection of bags of soiled articles should not be used for the distribution of clean laundry supplies as well.

Extra blankets and pillows which circulate indiscriminately among patients are vehicles by which staphylococci are commonly transmitted. Each patient should have his own extra supply, and each bed should have an individual cabinet in which this bedding may be stored. After the patient has been discharged and the bedding sent to the laundry, the cabinet should be washed thoroughly with disinfectant.

LAUNDERING

Bacteriological investigation has shown that the routine hot-water wash and subsequent steam-pressing of sheets and cotton garments usually is sufficient to kill staphylococci.[3,4] Care must be taken, however, that these linens are not subsequently recontaminated by careless handling. The hospital laundry must be designed so that clean linens are not folded in the same room in which soiled articles are sorted and washed.[4]

Adequate washing of wool blankets presents a difficult problem which has not yet satisfactorily been solved. Unlike cotton, wool will not withstand wash temperatures required to kill infectious bacteria. The temperature which must be used for washing wool (100° F.) is totally inadequate because staphylococci are killed only by washing at not less than 220° F. for half an hour.

Chart 2
Infections Which May Be Caused by a Single Kind of Staphylococcus

Trivial (pimple, sty, boil)
Serious (abscess, osteomyelitis, pneumonia)
None (carrier)

One approach to this problem has been the addition of a disinfectant to the rinse water as a substitute for heat, but this method has severe limitations. Often it will only reduce the number of staphylococci, and its value is then dubious. It may even be hazardous because unjustifiable confidence is placed in it. Finally, since the efficacy of different disinfectants varies, they should not be used empirically. Despite manufacturers'

(Continued on next page)

claims, many disinfectants presently on the market are poor. Also, the action of some is neutralized in combination with certain soaps and detergents.

Accurate bacteriological evaluation of disinfectants under practical laundry conditions is difficult and seldom can be done adequately by a hospital diagnostic laboratory. The hospital wishing to consider this complex problem should seek competent bacteriological guidance from a state or federal public health laboratory.

Intensive study has been made of disinfectants which may leave a residual film on the blankets when added to the wash water. These include cetyltrimethylamine bromide (Cirrosol)[5,6] and the synthetic phenols (O-Syl[7] and Amphyl[8]). Disinfection obtained with them appears promising, and it is believed that if they are properly used their residual film will prevent bacterial multiplication. However, the practical value of residual disinfectant remains in doubt. It may prove overrated since suppressing bacterial multiplication is no substitute for actual destruction. Staphylococci which are merely prevented from multiplying on a blanket still may produce infection when transferred from blanket to patient.

It is noteworthy that some of those who have studied blanket-laundering most intensively have concluded that sterilization by boiling affords the only completely reliable method for blanket decontamination.[3] Heat-stable fabrics which can be substituted for wool in blanket manufacture have been investigated by a British group. They report a synthetic polyester fiber commercially marketed as Terylene to be highly satisfactory.[3] Similar fabrics must be available on the American market, but, as yet, little thought has been given to their possible use. An ideal synthetic fabric would (1) not shrink or mat when washed in boiling water; (2) have a warmth and weight similar to that of wool; (3) be of a texture which would release only a minimum amount of lint, and (4) have a cost approximating that of wool.

DISINFECTION OF MATTRESSES, PILLOWS

It is seldom appreciated that bacteria, including staphylococci, readily sift through pillowcases and mattress pads. Unfortunately, decontamination of pillows and mattresses presents a problem even more difficult than decontamination of wool blankets. Mattress autoclaves, although available, are impractical for many hospitals. Impregnation of mattress and pillow ticking with disinfectant has been suggested,[9] but as in blanket disinfection, the destruction of all pathogenic bacteria is not entirely certain.

Plastic mattress covers which can be thoroughly scrubbed after each patient's use probably offer the best solution short of autoclaving. Disposable lightweight plastic sacks appear to afford an economical and practical way to eliminate pillow contamination.

CLEANING FLOORS, FURNITURE

Extreme care must be taken that cleaning procedures do not further distribute rather than eliminate staphylococci borne on lint and dust.

Separate cleaning equipment should be provided for each hospital service—particularly for those in which staphylococcal infections are most likely to occur (nursery, maternity, and surgical). Such equipment should be designed so that it can be sterilized at frequent intervals—preferably daily.

Furniture-dusting should always be done with a cloth moistened with disinfectant, rather than a dry cloth.

Careful thought must be given to types of equipment used for cleaning hospital floors. Vacuum cleaners are unsafe because both dry and wet types usually expel bacteria in their outflow air stream.[10] Mechanical floor-polishers are to be avoided because most have no satisfactory way by which the brushes can be sterilized frequently.

Most floor waxes are open to criticism because, although their effect is esthetically pleasing, the hard surface they provide tends to redisperse dust rather than hold it down. Also, they mitigate against frequent floor-washing, although this disadvantage can be overcome with the water-based self-polishing waxes which are renewed daily.[10] Some waxes incorporate disinfectant with supposedly residual action, but it is probably unwise to rely too confidently upon their effectiveness. A safer substitute is frequent floor-washing, particularly when it is done with some of the newer disinfectants (quaternary ammonium compounds or the synthetic phenols).

These are but a few of the possible housekeeping precautions which may be of help in controlling staphylococcal infection. Valuable suggestions may be obtained from the reviews of Starkey,[10] Letourneau,[11] and Brown.[12] Wholehearted co-operation of all hospital personnel (medical, nursing, and administrative) is necessary to carry them out effectively. There may be added costs. However, infectious outbreaks may be infinitely more costly to the hospital, and to the individual patient an infection acquired in a hospital is both costly and catastrophic.

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Hospital Purchasing and Stores

Another in a series on hospital organization, based on lectures given at meetings of the Association of Western Hospitals and allied state groups

II. Storekeeping and Inventory Control

By John H. Gorby*

• The maintenance of stores enables the hospital to purchase larger lots with corresponding discounts for quantity purchases. However, carrying excessive stores can waste money by incurring carrying charges, loss, and obsolescence.

For efficient storekeeping, the first need is to determine which items should be kept in stock. Ordinarily, these items will be ones used in volume by many departments, including maintenance and repair articles, soaps and solutions, and housekeeping and office supplies. Drugs should be stored separately, in the pharmacy, and handled by the pharmacist.

Since choice of what to store is usually based upon rates of usage, determination of items to stock is difficult without adequate stock record cards, which indicate usage. Stock record cards should be designed to include the following data:

Name of item.

Maximum and minimum stock levels, and reorder point.

Specifications for the item, and perhaps an item number.

Vendors from whom the item may be secured.

Unit cost for each vendor.

Purchase orders issued, filed by vendor.

Issues from stock.

Receipts given.

Balance of stock on hand.

Stock record cards also may be used to initiate purchase orders. In such cases, when the stock level reaches the reordering point, the stock records clerk should notify the storekeeper who should make a physical inventory; after the inventory, the clerk should prepare a purchase order for the signature of the purchasing agent. This procedure eliminates the requirement for a requisition of any type. Furthermore, if each stock item is inventoried physically at the time an order is issued, annual or other periodic physical inventories are not needed.

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Each item of stock should be maintained in a specific place, and the location should be entered on the stock record card. Items should be identified with bin tags and, if feasible, the bin tags should contain a record of additions to, and issues from, stock.

If different forms are used for purchase requisitions and stock requisitions, the latter should be designed to include the price of the issued item. Before the copy of the filled requisition is returned to the requisitioner, the price of the item should be entered and the requisition sent through the business office for recording of charges to the department.

The number of items carried in stock can be reduced if appropriate policies and practices of standardization and simplification of materials are established and maintained.

PERPETUAL INVENTORY SYSTEM

Perpetual inventory is a system which permits immediate determination of how many units of any particular item are on hand at any particular time. It also gives the cost basis and the unit cost of each item. Such a system has a great many advantages, even in a smaller hospital. How much of each item is on hand and the value of any particular item can be determined without making a physical count. In addition, the system provides a history of the use of a particular product. This enables intelligent planning of purchases.

Entries are made on the perpetual inventory card from only two sources: the first is the requisition, and the second is the receiving copy of the purchase order itself. Ordinarily, after the receiving copy is filled in, it is routed to the storeroom where the information is entered on the perpetual inventory card.

FORMS OF PERPETUAL INVENTORY CARDS

The two most commonly used forms of cards used in perpetual inventory are these:

1. A loose-leaf vertical card may be used. This fits

(Continued on next page)

into a metal box, about 18 inches by 36 inches in size. The cards are notched at the bottom and fitted into categories. Many hospitals use a numbering system which identifies a particular article by a specific number. For example, syringes would be the 500 series, cotton balls, the 700 series.

2. The other form employs a visible index or Kardex type of control. The cards are maintained in a drawer which may be pulled out when entries are to be made.

EXTENDING COSTS

There are several systems for extending costs and charging the using department. The two most popular ones are the "first in, first out" and the "average costs" systems.

First in, first out may be illustrated by the following example: A hospital orders 24 dozen cotton balls at $1.50 a dozen, then orders another 24 dozen cotton balls at $2 a dozen; the hospital actually has on hand 48 dozen cotton balls at an average cost of $1.75 a dozen.

The first in, first out method presumes that the first cotton balls requisitioned will go out at $1.50 a dozen. After 24 dozen cotton balls have been requisitioned, then the orders go out at $2 a dozen. Actually, nothing is gained, as far as hospital accounting is concerned, by using the first in, first out method. A system of average costs is much simpler.

In this system, costs are averaged each time a new lot is received, and when the unit price is different from the existing average. This system has the very desirable result of avoiding an unusually low cost for items during a period when low cost merchandise is being used and unusually high costs at another time, when higher cost merchandise is being used. In other words, the average cost system helps smooth out the cost curve.

It is desirable to establish a method to provide continual verification of the accuracy of the inventory record. Such a method may also eliminate the annual inventory.

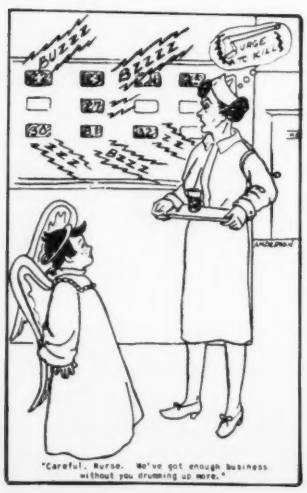
For sampling purposes it is recommended that periodically—at least once a month—no less than ten cards should be pulled from the perpetual inventory file. These cards should be verified by actually comparing the inventory with the number of items on hand. This system has a two-fold effect: First, it insures the accuracy of the inventory record; second, it impresses upon all personnel responsible for handling the inventory the fact that it is being checked and that extreme care must be used in the handling of all items and supplies.

If these monthly verifications by samplings indicate that the record is being kept consistently and accurately, the annual inventory may be eliminated. It is necessary only to run a tape on the totals shown on the perpetual inventory card and compare the figure with the control in the general ledger to make certain that charges are being properly entered and credited.

(Continued on page 51)

Introducing Gabby . . .

A big-eyed little angel named Gabriel, for the Archangel, and Gabby, for short, is becoming a friend of more and more patients, nurses and other hospital people as he enlarges his rounds. He is appearing regularly on bulletin boards in many departments.



Three years old by earth standards, Gabby's knowledge is ageless, his humor gentle, his comments slightly pointed or warmly ingratiating—depending on the subject he is highlighting at the moment in his education of hospital personnel.

Prepared by the Rev. John J. Lazarsky, Santa Rosa Hospital, San Antonio, Tex., Gabby cartoons are available through the Association of the Catholic Chaplains of Texas Hospitals, 745 W. Houston St., San Antonio, Tex. A 10-week series costs from $5 for 10 copies, to $10 for 25 copies. Single cartoons may be ordered in lots of 100 ($5.75) to 250 ($10.75).

Regional Differences in U. S. Hospitals

By Louis Block, Dr. P.H.

Tenth in a series

• There are regional differences in the numbers and kinds of hospital facilities and services available, and in their utilization. The role of the regional hospital can best be portrayed by studying it as a part of the total United States picture, and as an entity in itself.

The largest amount of total expenses in:

1. All hospitals was in the Middle Atlantic region.

2. Short-term general hospitals was in the Middle Atlantic region.

3. Nonprofit short-term general hospitals was in the Middle Atlantic region.

4. Proprietary short-term general hospitals was in the West South Central region.

5. Governmental (excluding federal) short-term general hospitals was in the Middle Atlantic region.

6. Long-term general hospitals was in the Middle Atlantic region.

7. Psychiatric hospitals was in the Middle Atlantic region.

8. Tuberculosis hospitals was in the Middle Atlantic region.

9. Federal hospitals was in the South Atlantic region.

More than half of the total expenses in all regions are in short-term general hospitals. In this group, nonprofit controlled hospitals account for the largest share.

In the West South Central region the proportionate share of total expenses in proprietary and governmental (excluding federal) short-term general hospitals is greater than in other regions. Proportionately, the East South Central, West South Central, and Mountain regions have a larger share of their expenses in federal hospitals than do the other regions.

*Based on the 1956 Administrators' Guide Issue, *Hospitals*, Journal of the American Hospital Association.

*Total Expenses**

1. The Region as a Part of the United States

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific	Total
Total	8.0	25.3	11.2	20.5	4.6	8.6	6.9	3.5	11.4	100.0
Short-Term General	7.8	23.2	10.5	22.7	4.3	9.4	7.3	3.4	11.4	100.0
Nonprofit Short-Term General	9.2	24.7	8.9	25.0	3.6	9.8	5.4	3.3	10.1	100.0
Proprietary Short-Term General	1.2	14.9	18.9	4.8	9.8	7.3	25.7	1.4	16.0	100.0
Gov'tal (Excl. Federal) Short-Term General	4.5	20.5	13.9	19.3	5.4	8.4	9.2	3.9	14.9	100.0
Long-Term General	9.6	37.3	7.7	22.0	1.9	4.3	2.3	1.7	13.2	100.0
Psychiatric	10.1	39.9	8.0	17.6	2.5	7.2	4.1	2.4	8.2	100.0
Tuberculosis	8.3	21.6	13.4	26.1	4.9	6.7	4.1	3.8	11.1	100.0
Federal	5.9	15.7	17.9	13.1	8.5	8.1	10.4	5.9	14.5	100.0

2. The Region as an Entity in Itself

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
Short-Term General	60.1	56.5	57.5	67.8	57.9	67.2	64.3	58.1	61.5
Nonprofit Short-Term General	52.0	43.8	35.6	54.5	35.4	51.4	34.9	42.0	39.6
Proprietary Short-Term General	0.5	1.8	5.3	0.7	6.6	2.6	11.5	1.3	4.4
Gov'tal (Excl. Federal) Short-Term General	7.6	10.9	16.6	12.6	15.9	13.2	17.9	14.8	17.5
Long-Term General	4.2	5.1	2.4	3.7	1.4	1.7	1.2	1.7	4.0
Psychiatric	20.7	26.0	11.8	14.1	9.1	14.0	9.9	11.2	11.9
Tuberculosis	3.9	3.2	4.5	4.8	4.0	2.9	2.2	4.0	3.6
Federal	11.1	9.2	23.8	9.6	27.6	14.2	22.4	25.0	19.0
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Consultant's Corner

By John G. Steinle

Q. Relatives often worry when patients are in surgery a long time. They do not understand the recovery room concept. Do you know of any effective device to explain the recovery room?

A. A number of hospitals have developed very effective pamphlets explaining, with illustrations, the recovery room and its uses. These are given to patients and their relatives.

For example, Robert Packer Hospital, Sayre, Pa., has devised an excellent "fold out" that explains the function and the role of the postanesthesia recovery room, and includes drawings showing equipment used. The narrative part of this pamphlet includes the following statement:

> "A surgical patient who has had a general anesthesia will be taken to this room immediately following the operation. The patient will remain in the postanesthesia room until he regains consciousness, which will normally be about the same amount of time that he was under the anesthesia. Immediately after the patient regains consciousness, he will be transferred to his bed in the hospital.
>
> "As an added precaution and in the best interest of the patients, no visitors will be allowed in this room. The floor will be notified by telephone regarding the patient's condition at frequent intervals.
>
> "The facilities of this room will be made available to most surgical patients who have had a general anesthesia, and those for whom especially close observation is indicated.
>
> "Private duty nurses will accompany their patients to the postanesthesia room and assist in their care."

Q. Is it common practice for hospital purchasing agents to obtain written quotations? What are the advantages of obtaining written quotations versus buying on the basis of experience but without a formal bid?

A. Frequency of purchasing on written quotations is in direct ratio to size of the institution. Purchasing practices in large hospitals are more formal than in small hospitals because (a) soundly-based perpetual inventory records, upon which formal bidding can be requested, are more likely to be maintained in larger institutions; (b) in many cases, quantities involved do not result in attractive discounts for the small purchaser; (c) it is often to the advantage of the small hospital virtually to requisition from the shelves of a dealer rather than to tie up huge amounts of capital funds in space and inventory.

In the hospital field as a whole, routine purchasing on written quotation is less common than purchasing from dealer stocks as the need arises.

Some advantages of purchasing on formal written quotation are these:

—Written specifications provide reasonable assurance that the product or equipment under bid will conform to service or performance standards required by the purchaser.

—Vendors are able to grant substantial price advantages when they are assured of known volume and a predetermined delivery schedule over an extended period of time.

—Purchasers are relieved of the costly, time-consuming detail of hand-to-mouth ordering, receiving, and inventory-taking.

—Buyers are protected against price increases during the life of the purchase agreement.

—Since past history of actual consumption, performance, price, and source of items under bid must be known, in order to project future needs intelligently, maintenance of accurate, complete perpetual inventory records is encouraged. As a concurrent benefit, consistent requisitioning and costing systems become prerequisites to meaningful inventory summaries, because these records are the basis for effective bid purchasing.

—Purchasers who are about to make long-term commitments tend to examine more critically past performance and consumption records on the products or equipment concerned.

—In many instances, volume, delivery, and shipment factors which enter into bid purchasing make it possible for purchasers to deal advantageously with prime suppliers rather than with "middle man" dealers and distributors.

Q. Is it common practice to have a salary differential for the nurse in charge of units during the 4-to-12 and the midnight-to-8 a.m. shifts?

A. A number of hospitals follow this practice, which is an excellent one. The job title in such a case is usually "charge nurse." Thus, the professional titles for the nursing units are head nurse, charge nurse, and general duty nurse.

The charge nurse has a great deal of responsibility and often has to make decisions and take independent action. She should be compensated accordingly.

In Anticoagulant Therapy

Why HEPARIN?

Heparin is the body's own anticoagulant. It is a substance which is essential in maintaining the fluidity of circulating blood and is found in all mammalian tissues. Heparin is produced in the body by mast cells which occur in perivascular connective tissue everywhere. It is found in greatest abundance in the liver and lungs. The therapeutic usage of heparin is based upon its property to inhibit the coagulation of the blood. Its timely administration will prevent thrombosis, and, even if administered after thrombosis has set in, it will prevent further propagation of the clot. In all conditions in which thrombosis or the extension of an already existing thrombus is to be avoided, the use of heparin is advisable.

When injected, heparin's *natural* action in the body is to prevent the conversion of prothrombin to thrombin (antithrombin action). By neutralizing thromboplastin, it also acts as an anti-prothrombin. Further, it inhibits the agglutination and deposition of platelets, thereby discouraging thrombus formation. Heparin acts directly on blood clotting constituents and does not destroy any component of blood or permanently change the normal constituents of blood. For emergency use it is the *only* anticoagulant which acts almost immediately (within a few minutes on intravenous injection). For safety's sake, its action can be terminated rapidly when necessary. Because of its rapid action, most authorities agree that initial control of thrombo-embolic diseases should be effected by means of heparin administration.

Significant differences exist between heparin and oral anticoagulants:

	HEPARIN	ORAL ANTICOAGULANTS
Latent Period	Immediate Effect I.V.	24-48 Hours
Effect on Prothrombin Level of Blood	Slight	Markedly Lowered
Effect on Coagulation Time of Blood	Markedly Prolonged	Slightly Prolonged
Regulation of Anticoagulant Action	Easy	Difficult
Suspension of Action	Rapid	Delayed
Duration of Anticoagulant Action	12-24 Hours	Several Days
Mode of Administration	Parenteral Only	Oral

Combined heparin-oral anticoagulant therapy overcomes one of the disadvantages of oral therapy by making available the immediate action of heparin on coagulation time during the induction period of the oral drug.

Thus the use of oral anticoagulants in hospitals complements but does not replace the use of heparin. To date, no other substance has proven as effective as heparin in the prevention and treatment of thrombosis and embolism.

Why LIQUAEMIN®?

Purified heparin was first made available to physicians and hospitals in the United States in 1939 as Liquaemin Sodium 'Organon'. Organon's experience in the manufacture of heparin thus antedates that of all other companies. Because and through this long experience in heparin manufacture, not only is Liquaemin Sodium biologically standardized, but before its release is subjected to sixteen extra safety tests, several more than required by the U.S.P., to assure maximal effectiveness and safety of the preparation. Liquaemin Sodium offers only the purest grade of heparin, and solutions of Liquaemin are water-white in appearance. Thus, just as heparin has remained the only satisfactory compound of its group, Liquaemin has remained the standard heparin preparation since its introduction.

Liquaemin Sodium can be obtained in a variety of dosage forms and strengths, from the original low concentration of 1,000 U.S.P. Units (approx. 10 mg.) per cc for continuous intravenous drip, to the 20,000 U.S.P. Units (approx. 200 mg.) per cc in gelatin, to the 20,000 U.S.P. Units (approx. 200 mg.) per cc aqueous solution for convenient intramuscular depot anticoagulant effect. With its 20,000 U.S.P. Unit per cc aqueous solution of Liquaemin, Organon pioneered the now widely accepted concept that prolonged heparin effect can be achieved by injecting intramuscularly an *aqueous* solution of high concentration-low volume heparin.

These facts—dependability, purity, potency, safety—have established Liquaemin Sodium as the heparin of choice in hospitals throughout the United States.

Liquaemin Sodium is supplied in the following strengths and package sizes:

Aqueous Solutions

1,000 U.S.P. Units per cc (approx. 10 mg.)—10-cc vials

5,000 U.S.P. Units per cc (approx. 50 mg.)—10-cc vials; 1-cc ampuls

10,000 U.S.P. Units per cc (approx. 100 mg.)—4-cc vials; 1-cc ampuls

20,000 U.S.P. Units per cc (approx. 200 mg.)—2-cc vials; 1-cc ampuls; 1-cc ampuls with disposable syringe

In Gelatin

20,000 U.S.P. Units per cc (approx. 200 mg.)—2-cc vials

For detailed literature and dosage information, write:

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Review of Hospital Law Suits

By Leo Parker, Attorney at Law

• A higher court recently held that the legal rights of a father toward his child do not equal the authority of a properly authorized court. Hence, if a court decides that a child should be placed in a state hospital for mental illness, the father cannot obtain custody of the child.

For instance, in Elizabeh Hobart, 145 N. E. (2d) 205, it was shown that an affidavit was duly filed by Rachel Hobart, mother of a child, alleging that the child was mentally ill. All statutory requirements were duly complied with, the court found that the child was mentally ill and in need of special care and treatment, and ordered her committed to the Miami Valley Hospital. Upon application for review, the court held that all former custodial orders be vacated and that the child be committed to the Dayton State Hospital.

The child's father appealed to the higher court and asked that prior decisions be revoked so that he could have the child in his care.

The higher court held, first, that a lower court's power to make commitment to the state hospital of a child who is mentally ill is discretionary and that such exercise of power may not be disturbed unless there has been an abuse of discretion. Also, the higher court held that the child must remain in the state hospital, and said:

"We have reviewed the entire record and conclude that under the evidence the lower court had the right to find that the child is mentally ill and that its best interests require that it be hospitalized. It is only in the exercise of a fatherly instinct, for which he should be commended, that the father desires that the child be kept out of a public institution and turned over to him for custody and control. However, he has presented no plan which appears to be feasible and for the best interests of the child."

NET WORTH IS VALID TESTIMONY

Recently a higher court clearly upheld the law that a physician or surgeon can be convicted of federal income-tax evasion, if proof is given that his net worth today is greater than indicated by his income-tax reports a year or more previously.

In Hasson v. Commissioner of Internal Revenue, 239 Fed. Rep. (2d) 778, there was no proof that Hasson had failed to file correct federal income-tax returns, except that at the end of a three-year period he was $14,350.37 richer than he should have been according to his reported income and expenses.

The lower court convicted Hasson of federal income-tax evasion. The higher court approved the verdict, saying:

"The employment of cash hoarding is a typical method used by tax evaders. The net worth plus expenditures method does not identify the sources of the total net income thus calculated, and the burden of disproving the net worth determination of taxable income is upon the taxpayer."

JURY MUST HAVE ALL EVIDENCE

Recently a higher court held that a jury's verdict will be reversed if the testimony shows that its members were not permitted to read all relevant testimony.

For instance, in Joseph v. Groves Latter Day Saints Hospital and Dr. J. H. Cariquist, 318 Pac. (2d) 330, the testimony showed that ten days following an operation for the removal of a tumor, Mrs. Lucille Joseph died in the Groves hospital of a "lower nephron nephrosis" inflammation of the kidneys. Her husband sued alleging that the hospital had negligently administered a transfusion of incompatible blood which brought on the kidney infection, proximately causing her death.

The jury held neither the hospital nor surgeon liable. The higher court reversed this verdict because, during the trial, the lower court refused to allow the jury to read certain notations and entries upon the hospital record made by two doctors, V. L. Rees, M.D., and Kenneth A. Crockett, M.D., who had been called in to consult with respect to the treatment of Mrs. Joseph. The notations were:

"Pelvic laparoling 4-4-53 followed almost immediately by a chill and dark urine . . . This pat. is going into some type of renal decompensation possibly on the basis of a transfusion reaction . . ." Signed "V. L. Rees." And at the bottom of the same page of the Progress Notes: "This is undoubtedly a lower nephron syndrome from hemolytic blood transfusion . . ." Signed "KAC."

The higher court said that the jury should have been allowed to read these entries, saying:

"The entries have a direct bearing on a critical and disputed issue: whether Mrs. Joseph received a transfusion of incompatible blood which caused her death."

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ALCOHOLISM

(Continued from page 38)

moral responsibility, and sometimes it deprives him of responsibility completely.

Among alcoholics there are weak-willed and strong-willed persons, as there are in any class of people. Alcoholics may have as strong a will as anyone in other matters, but in the matter of alcohol—and perhaps only in this matter—they are weak. The alcoholic, having developed a strong weakness for the "stuff," becomes the victim of the vice of inebriety. But even this vice, when in operation, can lose its moral quality of guilt in the alcoholic when the intellect throws a road block in the path of the will, stopping it in its tracks and hindering its operation. Very often strong motivation coming from the intellect can give needed strength to a weak will for a successful outcome; but not when compulsive thinking is at work with its morbid complexes.

A drunkard drinks because he wants to drink; the alcoholic drinks because he has to. A drunkard could stop drinking if he wanted to; an alcoholic may not want to get drunk, but he feels powerless in his struggle with the overwhelming and irresistible impulse. The drunkard can take alcohol or leave it, depending on his will; the alcoholic cannot. The excessive drinker can live without it, though with difficulty; the alcoholic cannot live without it any more than he can live with it. The rock-bottom drinker feels so compelled to drink, particularly when he is under stress or strain, that one drink is too much for him and a hundred are not enough.

A drunkard gets drunk because of a wrong decision of the mind and will at the present moment, and he sins; an alcoholic becomes inebriated because of a built-in uncontrollable impulse developed over a period of years by wrong decisions in the past. One drink, or even a sniff of it, can act as a trigger which sets off a series of drinking episodes.

The alcoholic may have little or no guilt in the later stages of his alcoholic state; he may reach a point at which responsibility is greatly diminished and even eliminated. In the beginning as well as in the progressive stages toward alcoholism, which usually last for years, the voluntary element and responsibility are present; but as alcoholism increases, these decrease. The drunkard fails to master wrong sentiments, wrong thinking, and wrong motivation; the alcoholic is mastered by morbid complexes and an abnormally abnormal fascination for liquor.

Alcoholism as a physical disease is frequently prior to other physical ailments; as a sickness of the mind it is often posterior to other psychical illnesses. As a moral ailment it is not infrequently prior and posterior to other moral and spiritual ailments. In nature it happens that the effect often becomes the cause of more of the same or of something kin to it. In the case of vice and moral weakness it can become a very vicious circle.

The alcoholic as an alcoholic is a morally sick person, and because he is an alcoholic he is disposed to become an even less moral and spiritual person. Although some moral and spiritual deterioration antecedes alcoholism, greater moral decline and spiritual

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deterioration accompany its progress, and they advance rapidly after alcoholism sets in.

Actual case histories of alcoholics show this deterioration in no uncertain terms. Although the behavior pattern varies from one individual to another in detail and degree, there is a certain formal common denominator. Moral ideals and principles are gradually dulled; moral virtues—honesty, truthfulness, humility, modesty, purity, respect—progressively leave him. Spirituality goes out the window—he neglects prayers, devotions, sacraments, and church attendance. Undesirable characteristics increase—self-defense and self-deception (rationalization, alibis, excuses, lies); selfishness; self-centeredness; resentment toward all, especially those close to him (family, friends, boss); rejection of faith, and even God. The alcoholic is at variance with the whole world—he feels less and less peace with God, with neighbor, and with self—progressively less peace of mind, of heart, of soul, and of conscience.

In brief, alcoholism is not exclusively a disease, as are cancer, tuberculosis, or diabetes, nor is it solely a psychical ailment of the mind, nor is it exclusively a moral or spiritual condition. It is not something that belongs to the body alone, nor something that belongs to the mind alone, or to the soul alone. It is a combination of all these with other concomitant ailments on each of these levels. It is a very complex and excruciating sickness. If you do not suffer from it, thank God.

Next month Father Lazarsky will discuss the professional and medical treatment of alcoholism.

HOSPITAL PURCHASING

(Continued from page 44)

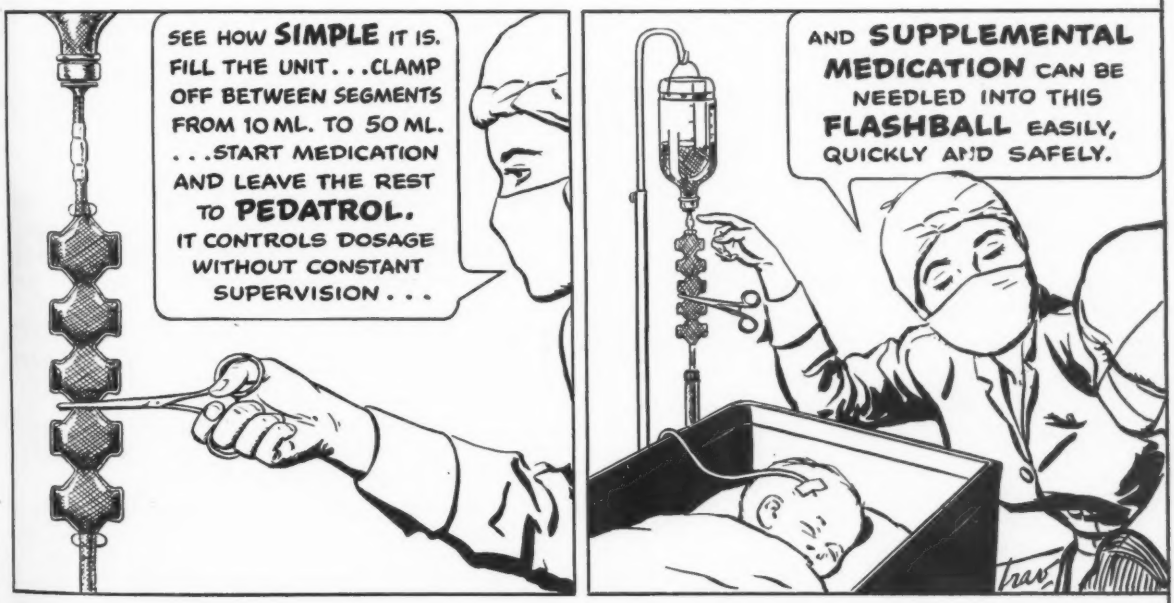
The extended cost figures on the perpetual inventory should be reconciled with the general ledger control, quarterly if possible. In no case should this reconciliation extend beyond a 6-month period. An error which has had less than ninety days to accumulate is much easier to locate than one which has had six months or a year. In fact, it is almost impossible to trace an error which occurred about twelve months previously.

Maximum and minimum levels should be entered on each card for each item of inventory. Thus, the purchasing agent, the storeroom clerk, and all personnel involved, have a clear indication of when the stock is getting down to the minimum point and it is time to reorder.

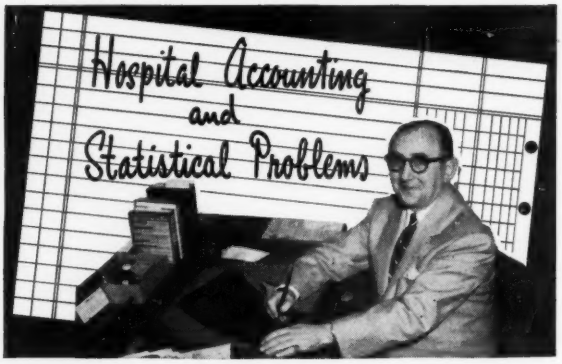
This system also allows shopping without pressure for immediate delivery. If minimum controls are not kept and reordering is not done until the stock is reduced to the last one or two units, there is always a feverish scramble to get the material before the supply is entirely gone.

Maximums provide an excellent method of preventing overstocking. Perpetual inventory cards should be revised periodically to make certain that maximums and minimums are being properly maintained and adhered to by all personnel.

Part I of this article, describing purchasing procedures, appeared in the September issue.


SEE HOW SIMPLE IT IS. FILL THE UNIT. . .CLAMP OFF BETWEEN SEGMENTS FROM 10 ML. TO 50 ML. . . .START MEDICATION AND LEAVE THE REST TO PEDATROL. IT CONTROLS DOSAGE WITHOUT CONSTANT SUPERVISION . . .
AND SUPPLEMENTAL MEDICATION CAN BE NEEDLED INTO THIS FLASHBALL EASILY, QUICKLY AND SAFELY.
trav.

pioneering parenterals for a quarter century



By David H. Tarlow, C.P.A.

Senior Partner, D. H. Tarlow & Co.

Hospital Accountants and Auditors, New York City

EDITOR'S NOTE: Mr. Tarlow's column appears in every other issue. Questions from readers are welcomed. They can be sent to HOSPITAL TOPICS at 30 W. Washington St., Chicago 2, Ill., or to Mr. Tarlow at 250 W. 57th St., The Fisk Building, New York 19, N.Y.

Q. Due to the illness of our accountant, I have been asked to take over the general ledger work in our hospital. I realize that my query may be elementary, but could you give me some guidance concerning any special procedures which may be followed in locating errors in the monthly trial balance? Further, what special text would you recommend for study and reference?

A. I would suggest that you obtain a copy of *Introduction to Principles of Accounting* by Harry A. Finney (5th edition, 1957, Prentice-Hall, Englewood Cliffs, N.J., 757 pages). The following procedures are recommended by Dr. Finney:

1. Refoot the trial balance.

2. See that the balances have been carried correctly from the ledger to the trial balance. Watch for:

   a) Differences between the balances in the accounts and the balances shown in the trial balance.

   b) Debit balances in the accounts entered on the credit side of the trial balance and vice versa.

   c) Ledger balances omitted from the trial balance.

3. Recompute the ledger balances. This will involve the following steps:

   a) Refooting the debit side and credit side of each ledger account.

   b) Recomputing the difference between the two sides of each account.

4. Check the postings from the journal to the ledger. Beginning with the first entry in the journal, see whether each debit and credit has been correctly posted. Watch for:

   a) Errors in amounts.

   b) Postings to wrong accounts.

   c) Posting a journal debit to the credit side of the ledger or vice versa.

   As each entry in the journal is traced to the ledger, place a check mark beside the amount in the journal and also beside the amount in the ledger. After checking of the postings has been completed, look for:

   a) Unchecked entries in the journal—see whether these items have been posted.

   b) Unchecked entries in the ledger—see whether these items belong in the ledger. It is possible that a journal entry has been posted twice, that one ledger entry has been checked, and that the unchecked ledger entry indicates a duplicate posting.

5. See that the debit and credit amounts in each journal entry are equal. Cross foot all journals of original entry. In looking for errors, be constantly on the watch for:

   a) Transpositions—such as $79.85 posted as $78.95.

   b) Slides—such as $0.75 posted as $75.

Locating Errors Through Division by 9

When the difference between the total debits and the total credits is divisible by 9, the error is likely to be caused by transposition or slide. Thus, posting $18 as $81 will throw the books "out" $63. This latter amount, divided by 9 gives 7, the difference between the two figures transposed.

If the difference is divisible by 99, the precise slide to look for can be determined. Thus, suppose the difference is $43.56. Dividing by 99 gives 44. The error is likely to be $44 posted as $0.44.

Locating Errors Through Division by 2

If the trial balance is "out" an amount which is exactly divisible by 2, the error may have resulted from posting to the wrong side of an account. Thus, posting a debit of $60 as a credit will result in a trial balance which is "out" $120. Examine the journal for entries which equal one-half the amount the trial balance is out, and follow these entries to the ledger.

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Included in the room scene above are: No. 90-65 All-Electric Push-button Hilow Bed; No. 300 Safety Sides, No. 9003 Bedside Cabinet with No. 307 Lamp, No. 90-614 Overbed Table, No. 90-26 Chest Desk, No. 90-07 Straight Chair and No. 9008 Arm Chair. Catalog and complete information sent on request.

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A parabola shade inside the outer shade permits spotting the light when intensive light is wanted for examination, or to reflect the light for reading. Inverting the shade gives indirect lighting. The shade is ventilated—will never become hot. There is a convenience outlet for electric appliances. Approved by Underwriters' Laboratories as safe for hospital use. Complete information on request.

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Personally Speaking

A. Boyd Anderson—has been appointed administrative resident, Western Pennsylvania Hospital, Pittsburgh. Before taking his graduate work at the University of Pittsburgh, Mr. Anderson was assistant superintendent, Washington (Pa.) Hospital.

Mary Helen Anderson, R.N.—has been appointed personnel director, Little Company of Mary Hospital, Evergreen Park, Ill. She received a B.S. in personnel from Northwestern University and completed the university's program in hospital administration in June.

Trannie A. Bennett—has replaced **Henry F. Thrasher** as administrator, Block-Chandler Hospital, Hartselle, Ala.

John L. Berry—has been named administrator, Marion County Memorial Hospital, Marion, S.C., replacing **Manson Turner,** who has become administrator, Ocean View Memorial Hospital, Myrtle Beach, S.C.

Robert Birke—has become administrator, Fairfield County Memorial Hospital, Winnsboro, S.C. He replaces **A. J. Woodring.**

John L. Brown—director of the Rockford (Ill.) Memorial Hospital since 1951, has become the director of a hospital under construction in Syracuse, N. Y.

Joe Carmical—is administrator of the new Forrest Memorial Hospital, Forrest City, Ark. The institution held dedication ceremonies June 29.

Booth Chilcutt—has succeeded **Willard M. Albury** as administrator, Monroe General Hospital, Key West, Fla. Mr. Albury retired.

Gerald B. Cole—has been appointed administrative resident, Indiana University Medical Center, Indianapolis. He is a graduate of Boston Unversity.

Anthony C. Cuty—former administrator, Ohio County Hospital, Hartford, Ky., has become administrator, Cibola General Hospital, now being built at Grants, N. Mex.

Shown above are participants in the Hospital Administrators' Development Program, held recently at Cornell University, Ithaca, N.Y. The 6-week advanced seminar series was supported by the Alfred P. Sloan Foundation. From left are: First row: Professors L. S. Reed, R. F. White, F. C. LeRocker (director), M. L. Roemer, R. A. Anderson, all staff members of the university's Sloan Institute of Hospital Administration.

Second row: Vincent D'Ingianni, M.D., director, Frank D'Ingianni Medical Foundation, New Orleans; Drew J. Thomas, executive director, Nathan Littauer Hospital, Gloversville, N.Y.; Ann May, administrator, Schoolcraft Memorial Hospital, Manistique, Mich.; George P. Harris, director, field service, The Duke Endowment, Charlotte, N.C.; Charence B. Hale, assistant administrator, Johnston Memorial Hospital, Abingdon, Va.

Third row: J. Patrick Thompson, administrator, Charlotte (N.C.) Rehabilitation Hospital; James E. Ferguson, administrator, University of Tennessee Memorial Research Center and Hospital, Knoxville, Tenn.; Col. Charles L. Kirkpatrick (MC), commanding officer, DeWitt Army Hospital, Fort Belvoir, Va.; W. Wyan Washburn, M.D., administrator, Gardner-Webb Junior College Community Health Center, Boiling Springs, N.C.

Fourth row: Theodore A. Bravos, assistant superintendent, Sonoma State Hospital, Eldridge, Calif.; Norbert M. Temple, director, Highland Park (Mich.) General Hospital; W. Harold O'Neal, administrator, Hazard (Ky.) Memorial Hospital; William H. Wood, Jr., associate director, Newport (R.I.) Hospital.

Fifth row: David A. Gee, associate director, Jewish Hospital of St. Louis; John R. Malban, executive assistant, C. F. Menninger Memorial Hospital, Topeka, Kans.; Alfred Sasser, Jr., superintendent, Glenwood (Ia.) State School; Robert E. Toomey, director, Greenville (S.C.) General Hospital; Robert J. Guy, administrator, Baton Rouge (La.) General Hospital.

W. J. Dye—has resigned as administrator, Mennonite Hospital and Sanitarium, La Junta, Colo., to become administrator and business manager, Woodcroft Hospital, Pueblo, Colo.

Mary E. Fallon, R.N.—is now assistant director of nursing service, Faulkner Hospital, Boston. Previously, Miss Fallon was associate director of nursing service, St. Joseph Hospital, Lancaster, Pa.

A. W. Ferguson—has been named associate administrator and business manager, Parkview Episcopal Hospital, Pueblo, Colo.

Franklin C. Fetter, M.D. — has been named director of medical education, Presbyterian Hospital in Philadelphia. Dr. Fetter was previously medical director, Philadelphia General Hospital.

Donald M. Fitfield—has resigned as manager, Lower Valley Hospital, Fruita, Colo., to become manager, Hilltop Tuberculosis Hospital, Corpus Christi, Tex. He is succeeded at Lower Valley by **Donald F. Hutchinson.**

Jack F. Flood—a retired major in the U.S. Air Force and former administrator, SAC Hospital, Homestead, Fla., has been appointed administrator, Palm Beach General Hospital at Lake Worth, Fla.

Kermit H. Gates, M.D.—director, Jackson Memorial Hospital, Miami, Fla., has been named head of

(Continued on page 57)

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The NITROFURANS

PERSONALLY SPEAKING

(Continued from page 55)

the Department of Hospitals, recently formed under the metropolitan Dade County, Fla., government.

Appointed assistant to the director of hospitals for the county is **Joseph Bertolami,** formerly assistant comptroller, Jackson Memorial Hospital.

The former associate director of the Jackson hospital, **William F. McLaughlin,** has been named director, Dade County Hospital, Kendall, Fla.

Dan Gibson—has been appointed administrator of a Pawnee, Okla., hospital.

Doris Gosnell, R.N.—has been appointed associate director of nursing in charge of education, Western Pennsylvania Hospital, Pittsburgh.

Also at Western Pennsylvania, **Kathleen Nicolette, R.N.,** has been appointed head nurse, emergency room.

Kenneth Haeger—has been appointed administrator of a Hominy, Okla., hospital.

Robert E. Harper, Jr.—has resigned as assistant administrator, City of Memphis (Tenn.) Hospitals, to become administrator, Capitol Hospital, Milwaukee.

Joseph C. Hiebel—has been appointed personnel director, Hospital of St. Raphael, New Haven, Conn. Formerly Mr. Hiebel was administrative assistant, Malden (Mass.) Hospital.

Alberta Hilton, R.N.—has been appointed director, School of Nursing, Little Company of Mary Hospital, Evergreen Park, Ill. **Imogene King, R.N.,** has been named assistant director of the school.

Miss Hilton was formerly assistant director, nursing education, Presbyterian-St. Luke's Hospital, Chicago. Miss King had been a clinical instructor and associate director of education, St. John's Hospital, St. Louis.

James E. Johnson—has been named assistant administrator, Mercy Hospital, Urbana, Ill.

Eugene Lasater—has been named administrator, Pacific Communities Hospital, Newport, Ore. He was formerly administrator, Ocean Beach Hospital, Ilwaco, Wash.

Eleanor Lee—director, nursing service, Presbyterian Hospital in the City of New York, has been appointed associate dean for nursing, Columbia University Faculty of Medicine. She has been at Presbyterian since 1924, when she joined the staff as instructor and educational director.

B. D. Mabry—is administrator of the newly opened Little River County Hospital, Ashdown, Ark. The first patients entered on July 21.

Dorothy Major, R.N.—director of nurses, Louisville (Ky.) General Hospital, has resigned to continue studies for a doctorate degree.

Richard M. Malone — previously assistant administrator, Baton Rouge (La.) General Hospital, has been named administrator, Jefferson Davis Memorial Hospital, Natchez, Miss.

Harriet L. Mather—has retired as director, Mather School of Nursing, Southern Baptist Hospital, New Orleans.

George I. Mattix—has resigned as administrator, Morris Memorial Hospital for Crippled Children, Milton, W. Va., to become administrator, Herbert J. Thomas Memorial Hospital, South Charleston, W. Va.

Wiley E. Middleton—has resigned as administrator, Polk County Memorial Hospital, Mena, Ark.

James Moses—former administrator, Pawnee (Okla.) Municipal Hospital, has been appointed administrator, Cushing (Okla.) Municipal Hospital. Mr. Moses succeeds **A. B. Whitely,** who resigned.

Mother M. Callista — has been named administrator of Sacred Heart Hospital, Manchester, N.H., and **Marcel J. U. Letendre** has been appointed assistant administrator. Mother Callista was formerly superior, Mount St. Mary College, Hooksett, N.H.

John C. Neal—has been appointed administrative assistant, Crawford W. Long Memorial Hospital, Atlanta, Ga. He recently completed the course in hospital administration at Georgia State College of Business Administration.

Bill M. Provost—has been appointed administrator, Memorial Hospital, Adel, Ga.

Charles W. Pruitt, Jr.—has been appointed assistant director, hospitals and clinics, Teaching Hospital of J. Hillis Miller Health Center, Gainesville, Fla. Formerly, he was administrative assistant to the center's provost.

Other new appointments at the health center include: **Lucille T. Mercandante, R.N.,** assistant director, nursing services, in charge of in-service education; **Anne J. Vestal,** executive housekeeper; and **Josie M. Lewis,** chief medical record librarian.

Mrs. Garnett L. Radin—has been appointed director, Shriners Hospital for Crippled Children, Lexington, Ky. Formerly, she was assistant director. Mrs. Radin replaces **Eleanor Baird, R.N.** who is now administrator of all Shriners hospitals.

Poerner Riehl—has been appointed administrator, Polly Ryon Hospital, Richmond, Tex.

Leroy F. Riley—formerly assistant administrator, Research Hospital, Kansas City, Mo., has been named administrator, Hospital in the Pines, Lone Star, Tex.

George R. Rollo—former administrator, Marshall Browning Hospital, Du Quoin, Ill., is the new administrator of Monmouth (Ill.) Hospital. **Arthur B. Allaban** succeeds Mr. Rollo at Du Quoin.

Dorsye Russell, R.N.—is now director of nurses, Lynchburg (Va.) General Hospital.

Charles E. Schmitt—is new vocational director of rehabilitation, St. Mark's Hospital, Salt Lake City. He received his M.A. degree in educational psychology at the University of Utah and interned at the Utah State Office of Rehabilitation, Ogden.

Edith Showalter, R.N. — has become director of nurses, Waynesboro (Va.) Community Hospital.

(Continued on page 133)

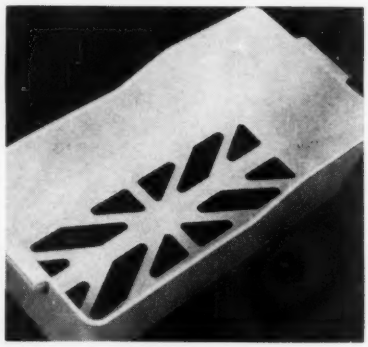
BUYER'S GUIDE

Ellen L. Davis

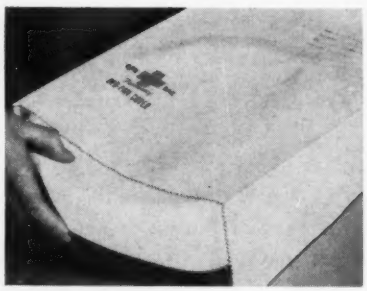
Buyer's Guide Editor

For further information on any of the products, please check the Buyer's Guide number on the reply card opposite page 152.

600. Bassinet basket



New germ-proof, hi-impact plastic bassinet basket can be cleaned with soap and boiling water, will still retain aseptic white color required for most nurseries. Permanently impregnated with Corobex, material will not support bacterial life, so remains bacteriostatic, fungistatic despite repeated washings, according to manufacturer. Size is 28½" x 13½", takes a pad size 27" x 13" or smaller. Princeton Plastic Products, Inc., Princeton, N.J.

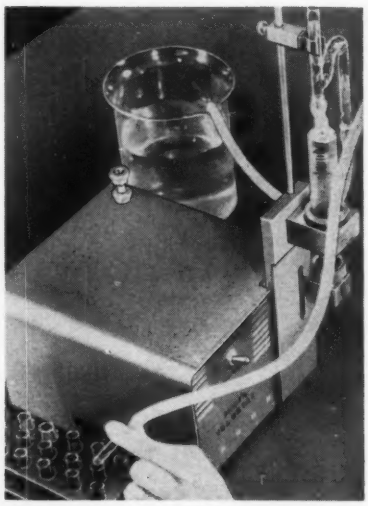


601. Tissue bed-pan cover

New lightweight tissue flushaway bed-pan cover has one panel omitted. Covers top, sides and one end of pan, leaving bottom uncovered for easy slip-on. Less paper goes into plumbing, resulting in savings on bag costs. Klean-Kan Bag Co., 64 E. 8th St., New York City.

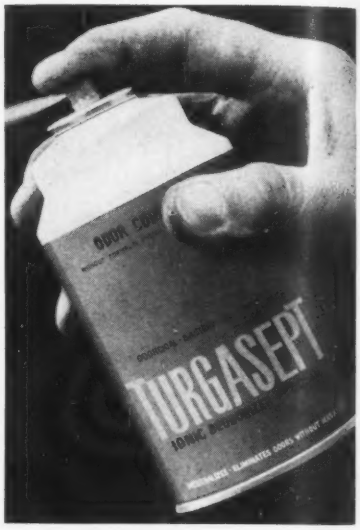
602. Floor covering

Scotch-Tred, a resilient, non-slip floor covering, is spark-proof, flame-resistant, long-wearing; resistant to chemicals, paints, solvents. Is applied by removing protective backliner, pressing to clean, dry surface. Flexible enough to be used in continuous strip on stairs. Resiliency that provides traction also makes material comfortable—and silent—to walk on. In 96′ rolls in 4, 6, 12, 18, 24, and 36" widths; in ¾" x 24" stripes and 9" x 9" tiles. Custom shapes to order. Minnesota Mining and Manufacturing Co., 900 Bush St., St. Paul, Minn.



603. Liquid dispenser

Volustat delivers liquids with a reproducibility of 15% with glass dispensing system, 1% with rubber system. Switch control discharges volume as a one-shot or as a continuously repeating process of 36 deliveries per minute. Fisher Scientific Co., 444 Fisher Bldg., Pittsburgh, Pa.



604. Deodorizer aerosol

Turgasept neutralizes odors for prolonged periods without masking, substituting new odor, or causing nasal anesthesia. Bactericidal and fungicidal to help reduce air-borne invaders. Can be added to hot water for floor, wall, and baseboard wash; or placed in air conditioners to deodorize large areas. Doho Chemical Corp., 100 Varick St., New York City.

605. Pharmacy bottle

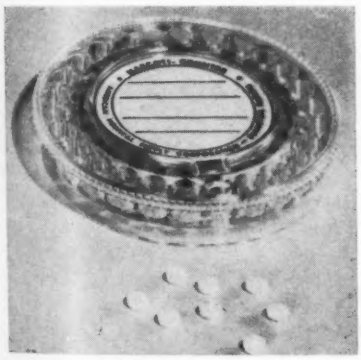
More functional container for heavy liquids and capsules is new wide-mouth round glass bottle with screw finish. High, straight sides provide space for label with large amount of copy. In clear glass; also available in amber to protect contents sensitive to light. Sizes from 15-cc. to 1,000-cc. capacities, heights from 2⅛", and in standard finishes from 24 to 48mm. Armstrong Cork Co., Lancaster, Pa.

606. Floor machine

Battery-powered machine cleans 20,000 sq. ft. per hour; dispenses clean water, scrubs, vacuums up dirty water. Four 24-volt battery pack housed in front for easy change. S. C. Lawlor Co., 124 N. Aberdeen St., Chicago, Ill.

607. Resuscitation truck

New lightweight truck designed to make oxygen quickly available in emergency. Steel, with baked enamel finish; two 3" wheels for silent mobility; rear hook for holding mask assemblies. Two rubber-cushioned retaining rings hold an "E" cylinder. Ohio Chemical & Surgical Equipment Co., Madison, Wis.

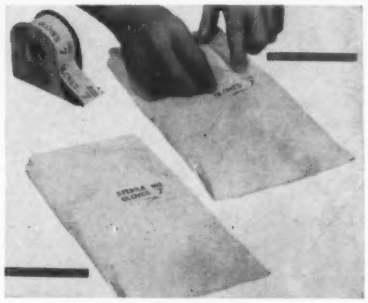


608. Narcoti-counter

Tomac large model counter is designed to hold 00 size capsules or tablets with diameter up to ½". Clear polystyrene can be washed or cold sterilized; holds 20 narcotics, keeps running count of remaining tablets. Repeated handling is eliminated, helping reduce inaccurate doses as result of chipping or powdering. American Hospital Supply Corp., Evanston, Ill.

609. Fast-setting plaster

Extra fast-setting plaster of Paris bandage and splint is precisely controlled in manufacture to obtain setting time of 2 to 4 minutes. Made of a gypsum uniformly impregnated by special process, bandage is creamy in texture, easy to work, gives good cast strength. Variety of sizes. Medical Fabrics Co., Inc., 100 Mill St., Paterson, N.J.



610. Autoclave label

New, pressure-sensitive label, invisibly preprinted. The word "sterile" becomes visible only after labeled item has been autoclaved at 250° F. for 15 minutes. Designed to seal; identify; and tell condition, number, and size of articles. Stock categories, or can be printed to custom size and copy requirements. Professional Tape Co., 355 Burlington Ave., Riverside, Ill.

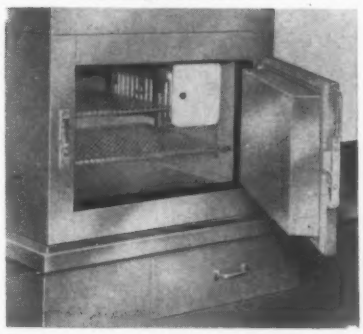
611. Pretreated mop

Ready-to-use Majestic sweeping mop, pretreated with Velva-Sheen to help reduce dust, is available in polyethylene bag. Mops do not require laundering. Velva-Sheen, for re-treatment, comes in sizes from 12 oz. bottles to 55 gal. drums. Majestic Wax Co., Denver, Colo.

612. Aerosol package

Aerosol Tronothane Hydrochloride, topical anesthetic for relief of surface pain, flash burns, abrasions, and itching, is available in aerosol package, permitting spray application over sizable area. Avoidance of direct contact with affected surfaces helps prevent contamination by microorganisms. Abbott Laboratories, North Chicago, Ill.

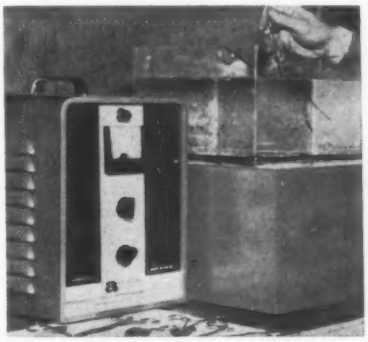
613. Refrigerator



Over counter refrigerator provides easy access to biologicals and specimens requiring normal refrigeration. Over-all size: 30" wide, 24" deep, 34½" high. Stainless steel exterior and interior. Condensing unit at top so unit may be placed flush to wall. Two-tray ice cube coil, perforated steel shelves, chrome-plated hardware. Jewett Refrigerator Co., Buffalo, N.Y.

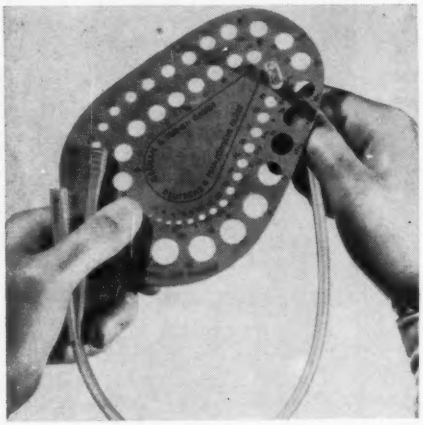
614. Dietetic gum

New sugarless gum, for persons on low-calorie and sugar-restricted diets, is claimed by manufacturer to retain enjoyable qualities in flavor, texture, and chewing consistency of regular gums. Sweetening agents from fruits and berries replace the usual sugar and syrup. Chiclecraft, Inc., 106 Gay St., Knoxville, Tenn.



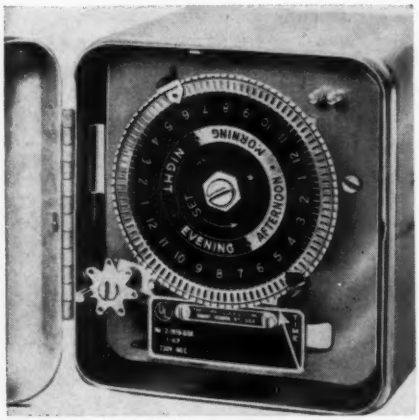
615. Ultrasonic washer

Utilizes silent sound waves to produce the cold boiling effect, known as cavitation. Powerful, high-frequency sound waves radiating through water literally tear away dried blood, other soils, from surgical instruments. Distributed by American Hospital Supply Corp., Evanston, Ill., and Wilmot Castle Co., Rochester, N.Y., under company brand name.



616. Catheter plug

Rusch balloon catheters are now available with a new self-sealing plug vulcanized in the funnel end. The plug contains a special compound which reseals needle punctures even after repeated use. Clearly defined puncture area on the end of the plug and extra long needle channel assist in avoiding accidental punctures of the funnel wall. Metro Medical Distributors, Inc., 794 Lincoln Place, Brooklyn, N. Y.

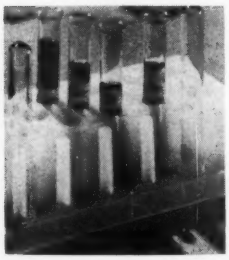


617. Switch for water softening equipment

Two-circuit time switch provides automatic regeneration of water softeners. Easy-to-set on-off trippers turn first circuit on at selected time. After required period, second circuit goes on for fast rinse. Cycle times for regeneration can be once a day, every other day, once a week, or every 12 days. Manual switch permits operation at other times without disturbing machine's master automatic cycle. Tork Time Controls, Inc., Mount Vernon, N.Y.

618. Scale liners

Two new nursery scale liners: 3-ply wet strength tissue 13½″ x 19″ replaces towels and diapers; 26½″ x 31″ white, water-repellent paper makes frequent scale sterilization unnecessary. Busse Hospital Products, 64 E. 8th St., New York City.



619. Tube holder

Three polyethylene racks, designed to accommodate different size tubes from semi-micro to very large. Smaller racks have row of studs over which clean tubes may be inverted for ready use. Washing cleans. Endicott-Seymour, P.O. Box 405, Ann Arbor, Mich.

620. Ladder

Saf-T-Stand ladder is topped by platform step 14″ deep, and roomy enough so that user can work from any direction without tipping or slipping. Curved top bar gives additional leaning support. Aluminized rust-resistant one-piece steel frame; heavy, non-slip rubber feet won't mar floors. Opens and closes easily, locks into position. In overall heights of 5′, 6′, and 7′. Novel Products, Inc., North Creek Road, Bellmawr, N. J.

621. Fluothane vaporizer

Vaporizer has been especially developed for use with Fluothane, potent, fluorinated, nonflammable, volatile anesthetic administered in known and low concentration. For use with Heidbrink equipment. Most popular technics will be semi-closed and non-rebreathing; double jar on vaporizer provides thermal reservoir. Ohio Chemical & Surgical Equipment Co., 1400 E. Washington Ave., Madison, Ohio

622. Glass-marking stylus

For chemical and heat-resistant marking on glass, quartz, ceramics. Layer of titanium deposited by Glascriber does not penetrate nor weaken surface, can be removed by brief immersion in hot hydrochloric acid. Markings present sharp, reflective surface, easily read. Anodized-aluminum holder with pocket clip. Oxford Laboratories, 111 Sutter St., San Francisco, Calif.

new

Tao*

PRONOUNCED TAY-O

(brand of triacetyloleandomycin with gluCOSAmine)

Capsules / Oral Suspension

designed for effective control of common gram-positive infections

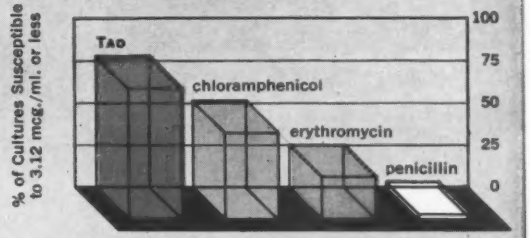
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . .

stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered without regard to meals.

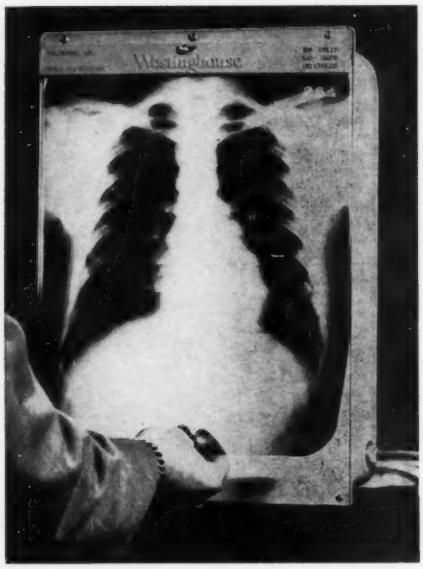
Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

Rx PFIZER NEW YORK 17, N. Y.

Division, Chas. Pfizer & Co., Inc. SCIENCE FOR THE WORLD'S WELL-BEING

*TRADEMARK



623. X-ray film viewer

New Monovue illuminator is designed for viewing all x-ray films up to 14" by 17". Total weight is 9 lbs.; viewing panel is made of ⅛"-thick Plexiglas. When operated at rated voltage—115 volts, 60 cycles—brightness of center of the viewing surface exceeds 400 foot-lamberts. Microswitch turns on the illuminator when film is inserted, giving automatic single film viewing. For continuous viewing, button on the film retainer can be used manually to control the light source. Unit is 19⅝" high, 14⅜" wide, 5½" deep. Westinghouse Electric Corp., X-Ray Dept., P.O. Box 416, Baltimore, Md.

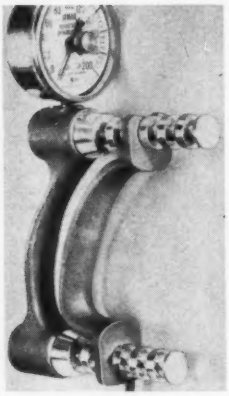
624. Baby cream

Rashene, new cream containing silicone and lanolin in a smooth, emollient base, helps protect against diaper rash, chafing, chapping, prickly heat rash, and minor skin irritations such as saliva and facial rashes. Available in 1½ and 3-oz. tubes. E. R. Squibb & Sons, 745 Fifth Ave., New York City.

625. Disinfectant-detergent

Tergisyl, new one-step disinfectant-detergent for hospitals, is claimed by manufacturer to cut labor costs on floor cleaning 47% by mop and pail method, 22% by machine scrubbing. Offers bactericidal fungicidal, tuberculocidal efficiency, with detergency sufficient to clean heavy soil. Has no effect on operating room floor conductivity. Lehn & Fink Products Corp., 445 Park Ave., New York City.

626. Dynamometer



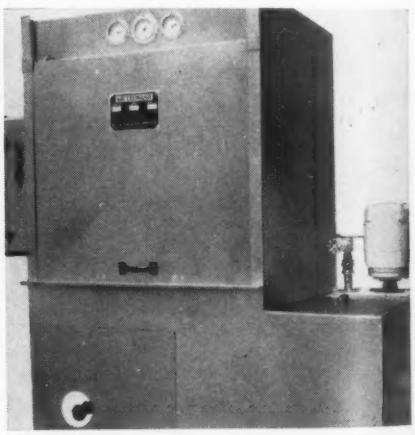
For evaluation and accurate grip measurement of injured hand. Jamar dynamometer measures therapeutic results, helps detect malingering. Handles adjust to six grip positions; 200 lb. maximum reading. Rehabilitation Products, division of American Hospital Supply Corp., Evanston, Ill.

627. Artery graft

New arterial graft is of Teflon, synthetic fiber which can be boiled in a mixture of concentrated sulphuric, nitric, and hydrochloric acids for 24 hours at 212° F. with no loss of tensile strength. Seamless, nonkinking tube may be cut and sutured without fraying or raveling; no heat sealing is required. C. R. Bard, Inc., Summit, N. J.

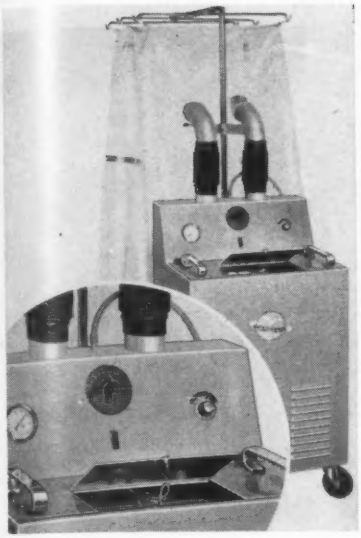
628. Mobile book truck

Constructed of heavy-duty welded steel, Pixmobile truck is finished in hammerloid enamel, and guaranteed against sagging, warping, maintenance need. Four-inch ball bearing, swivel wheels for silent mobility; wheel brakes for stationary position. Three W-shaped open shelves allow loading from either side, easy viewing from standing or bed position. Truck is 39" wide, 43½" high, 14" deep; 13⅛" between shelves. Advance Furnace Co., 2310 E. Douglas Ave., Wichita, Kans.



629. Pot and utensil washer

Handles all cooking, baking, serving, and storage utensils normally used in kitchens serving 5,000 meals daily. Tank capacity is 85 gal.; spray system is a vortex of 48 stainless steel nozzles. Following the wash cycle, 17 removable nozzles impinge hot water from 3 sides in a sanitizing rinse. Control panel for automatic and manual operation. Metalwash Machinery Corp., 900 North St., Elizabeth, N. J.

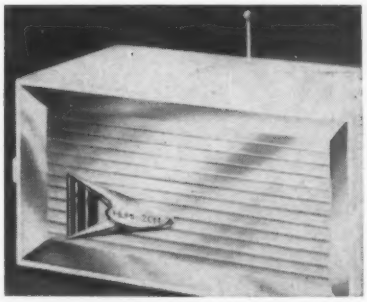


630. Oxygen tent

Continentalair M400H oxygen tent automatically maintains the desired humidity concentration within canopy without disturbing the prescribed oxygen concentration. Dial control, which permits selection of humidity percentage, will also govern aerosol dispensing of liquid medications. For inhalation therapy, a patented engineering feature prohibits recirculation of contaminated fog. Continental Hospital Industries, Inc., 18624 Detroit Ave., Cleveland, O.

632. Invalid walker

Provides excellent support for patients who need ambulation assistance. Lightweight enough to move easily. Width can be adjusted up to 27½"; two plastic knobs secure height to any of three levels; folds to 3"-width for storage. Wire utility basket hooks on side of walker to hold user's personal items. Heavily chrome-plated over steel. Rehabilitation Products, division of American Hospital Supply Co., Evanston, Ill.

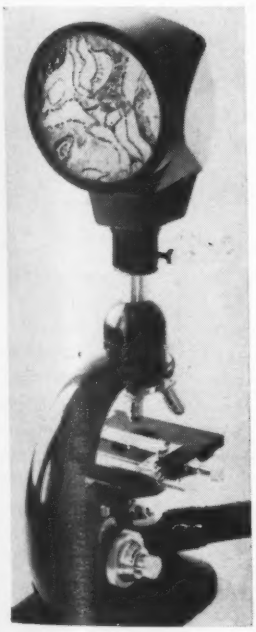


633. Portable humidifier

Automatically keeps humidity at the recommended 40-45% level in an average size room. Filled with ordinary water, unit screens room air through removable, washable filter, washes it in a saturation chamber, and recirculates the humidified air. Safeguard Corp., Lansdale, Pa.

634. Colostomy dressing

New Curity Pre-Pack colostomy dressing unit consists of Lisco sponges for prepping area; Telfa plastic-faced dressing with stoma opening; preformed Webril collar for support; length of Kerlix for use as fluff; Wet-Pruf abdominal pad to retain drainage. Packed in tear-open bag in order of use. Bauer & Black, division of the Kendall Co., 3409 W. Jackson Blvd., Chicago, Ill.

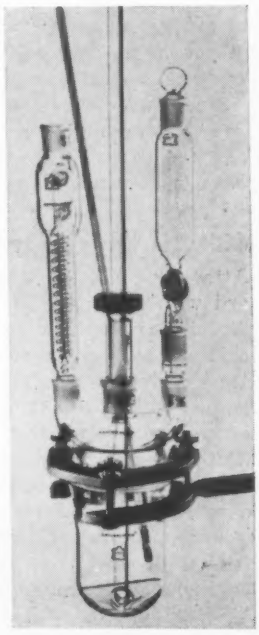


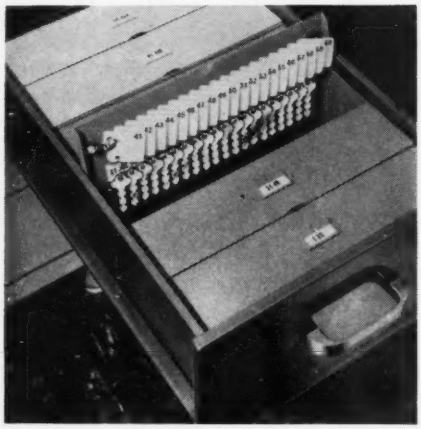
631. Viewscope

New Micro-Projection Viewscope will fit any microscope with a monocular tube, without special adjustment. Prism lens system produces clearly defined images on a 5"-diameter Fresnel lens viewing screen. Projected image has maximum resolution and uniform sharpness over entire field for viewing comfort. Coarse and fine focusing knobs on microscope bring specimen into focus on viewscope. The unit functions with any good light source. William J. Hacker & Co., Inc., 82 Beaver St., New York City.

635. Flask

Small reaction flask has been added to the Bantam-ware line of organic glass apparatus. Top and bottom flask sections are interchangeable and can be used separately. One top section can serve as a common component for 6 different flask assemblies ranging from 50 ml. to 500 ml. capacity. A 2" inside diameter at the flange facilitates the charging and emptying of small amounts of viscous material. The inside surfaces are easily accessible for cleaning. Kontes Glass Co., Vineland, N. J.





636. Key-filing unit

Portable key-filing unit fits desk drawers or file cabinets. Constructed of welded steel, unit is available in 3 sizes holding 40, 80, or 120 keys. Keys are attached to slotted vulcanized fibre tags, numbered for identification, and aligned on rigid coil wires for easy visibility. Index for lock and key information included. Cushman & Denison Mfg. Co., 730 Garden St., Carlstadt, N. J.

639. Urine test unit

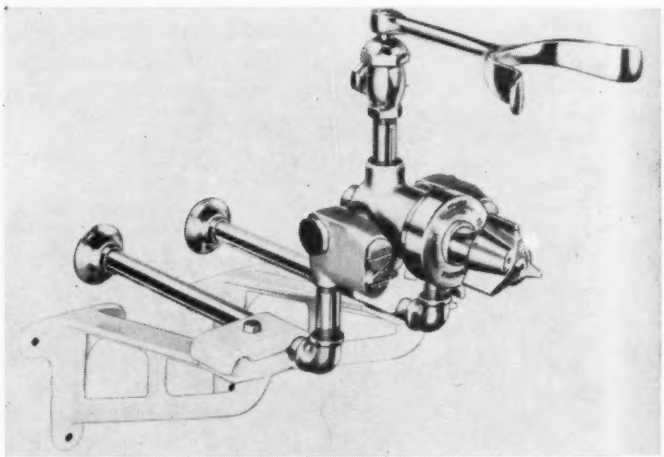
New Clinitest set is a streamlined design in two-tone grey plastic with each component compactly fitted to form self-contained unit. New features include visible test tube holder which exposes entire length of the test tube and provides a handle while test reaction takes place. Interchangeable refill feature permits use of either Clinitest tablets supplied in bottles or the sealed-in-foil tablets. Ames Co., Inc., Elkhart, Ind.

640. Paper cup holder

New combination holder and plastic-coated paper cup is designed to eliminate china at some servings, yet provide eye appeal and ease of handling. Well-balanced holder is formed of cycolac, to insure durability without scratching or breakage. China-Cote cup, with rounded, reinforced bottom, has 7-oz. fluid capacity; fits holder snugly, is disposable after use. Lily-Tulip Cup Corp., 112 E. 42nd St., New York City.

637. Knee-operated water mixer

For surgical wash-up sinks, a knee-operated version of the Hydroguard thermostatic mixing valve is available. Once the mixer has been turned to provide desired water temperature, user moves volume lever with knee to turn flow on and off. Mixer can be left at same temperature positions at all times, eliminating need for readjustment each time the sink is used. With a capacity of 10 g.p.m. at 45 lbs. of pressure, unit can provide water at any temperature between 65 and 110° F. Built-in shut-off stops water flow if temperature exceeds 110° F. Powers Regulator Co., 3434 Oakton St., Skokie, Ill.



638. Laundry spreader

Attachable on any make of flatwork ironer in standard widths of 100, 110, or 120 inches, new Spiroll direct-feed-spreader eliminates sheet shaking and carries the sheet through the ironer without guidance. Driven by the ironer, it requires no auxiliary motor. Sheets and smaller pieces may be fed one immediately after the other in continuous production, without adjusting the unit. Runs at a speed of 100 feet per minute with 100 psi steam; has a capacity of 850 sheets per hour. Available in 3-roll model, suitable for all smaller flatwork ironers, as well as in new 5-roll model for large flatwork irons having 8 to 12 rolls. D.F.S. Laundry Machine Co., 2464 Raleigh Drive, York, Pa.

641. Electronic thermometer

New Therma Meter is an electronic thermometer graduated within the range of 96 to 100° F., with nonbreakable stainless steel probes for oral, rectal, and axillary application. Designed to minimize time and effort in routine nursing procedures involving psychiatric patients; patients during surgery, shock treatment, or postoperative periods; and those restricted to iron lungs, oxygen tents, incubators, or other special equipment where it is not possible, nor advisable, to attempt a reading with a glass thermometer. Available as a unit with TPR Board, which includes a full face watch with second sweep, data pad with night light, and pencil clip. Medical Research Industries, P.O. Box 65, Cincinnati, O.

NEW AS TOMORROW'S SURGERY

The AMERICAN *ten eighty five* Major Surgical Operating Table

- ✶ **Compact, permanently mounted base with electro-hydraulic or hydraulic power lift**
- ✶ **Divided and removable foot section**
- ✶ **Head, back and seat sections X-ray penetrable**
- ✶ **Sliding Transurethral Tray**
- ✶ **"Winged" ether screen**

. . . these and many more exclusive features distinguish the 1085 as the major table *designed for modern surgery.*

The unparalleled versatility and precision of this new table are an incomparable aid to the surgical team . . . as helpful to the patient as "a third hand for the surgeon."

Write for your copy of illustrated brochure TC-294.

The 1085 is an addition to the Amsco line of Major Surgical Tables. The 1080 and 1080E will continue to be available.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

FILMS, NEW LITERATURE

642. O.R. transportation

New film, *Transporting the Patient for Surgery*, illustrates continuous action and co-ordinated teamwork in moving patient safely, comfortably, from bed to operating table to recovery room. On loan from ANA-NLN Film Library or Surgical Film Library, American Cyanamid Co., 30 Rockefeller Plaza, New York City.

643. Psychiatric guide

A Physician's Guide to Psychiatric Tests and Terminology, 40-page illustrated booklet, is a monograph outlining tests that have been used in psychiatric training, as well as over 200 terms often mentioned in discussing cases. Tests include the Rorschach Ink Blot Test, Figure Drawing Test, Word Association, and Picture Frustration Test. Schering Corp., Bloomfield, N. J.

644. Atomic models

Ten new atomic models for constructing organic metal chelate molecular models are described in a new 6-page, 5-color bulletin. It includes discussion of metal chelate bonding, dimensions and valence angles of models, and examples of their use in metal chelate compounds models. Arthur S. LaPine and Co., 6001 S. Knox Ave., Chicago 29, Ill.

645. Wall panels

Four-color booklet describes construction applications of prefinished wall panels. Made of permanently bonded laminates of vinyl over aluminum or steel, the panels combine the durability of metal and the toughness of vinyl; can be installed over any reasonably even base wall of plaster, dry wall, hard board, sheet rock, rock lathe, cinder or concrete block, poured concrete, or brick. Clad-Rex Corp., 2101 S. Indiana Ave., Chicago 16, Ill.

646. Laboratory centrifuges

Twelve-page 1958 catalog shows new centrifuges with keyboard control center, available in seven models. All feature ball-bearing motor, lubricated for life, and modern cabinet type construction. Chicago Surgical & Electrical Co., division of Labline, Inc., 3070-82 W. Grand Ave., Chicago 22, Ill.

647. Fiberglas chairs

Illustrated circular describes a new line of Fiberglas chairs designed for the hospital and surgical fields. Non-combustible and non-porous, Fiberglas has a tensile strength three times that of steel, is alcohol-resistant, never requires refinishing, cannot splinter. Color, impregnated throughout the material, cannot fade, wash off or chip off. Community Metal Products Corp., 1213 S. Circle Ave., Forest Park, Ill.

648. Antiseptic soaps

Advantages and uses of hexachlorophene liquid soap U.S.P. are discussed in a new product information bulletin. The soap, available in ready-to-use and concentrate form, is recommended for general and pre- and postoperative patient care, as well as for surgical scrub procedure. Industrial Soap Department, Armour and Co., 1355 W. 31st St., Chicago 9, Ill.

649. Hyperkinetic disorders

Chemopallidectomies in the treatment of hyperkinetic disorders are the subject of a 14-minute sound film sponsored by the Sister Elizabeth Kenny Foundation. Titled *Progress Report*, it is designed primarily for laymen so that facts about this development in neurosurgery may be more widely known and, perhaps, encouragement may be given to parents of afflicted children: United World Films, Inc., 542 S. Dearborn St., Chicago 5, Ill.

650. Scaffolding

Illustrated Bulletin No. 66 explains various applications of scaffold used as rolling towers and work staging for all types of interior and exterior maintenance and repair. Beaver-Advance Corp., Ellwood City, Pa.

651. Tax exemption

Nonprofit hospitals are jeopardizing their tax-exempt status and the tax deductibility of donations by engaging in commercial enterprises, according to a 40-page report titled *Doctors' Offices in Hospital-Financed Buildings*. The report states that 16 percent of the nation's nonprofit hospitals now subsidize offices and equipment for some senior physicians, thus violating local property exemptions and the Internal Revenue Code. The Foundation for Management Research, 121 W. Adams St., Chicago, Ill.

652. Ultrasonic cleaner

New high-speed Castle ultrasonic cleaner is described in Bulletin H246. Unit sends high frequency sound waves through a detergent to remove grease, dried blood and other soils from the surface of instruments, glassware, and small utensils. Tells how "frozen" syringes are freed, even "permanently" stained instruments cleaned. A load of 75 to 100 instruments can be cleaned in 7 minutes. Complete line is listed. Wilmot Castle Co., 365 East Ave., Rochester 4, N. Y.

653. Kitchen chart

Instructions on the proper care of ovens, broilers, and other gas-burning kitchen equipment have been charted for kitchen personnel reference. Chart shows how to avoid unnecessary maintenance costs, when and how to clean equipment; includes pointers for getting maximum cooking efficiency with minimum amount of heat. Gas Consumers Service, 347 Madison Ave., New York 17, N.Y.

654. Cryogenic refrigerator

Four-page folder describes new LNR-25B liquid nitrogen refrigerator for the storage of medical and biological specimens, chemicals and metallurgical samples, and for shrink-fitting small metal production parts. Unit holds 28.5 liters of liquid nitrogen, and about 382 cu. in. of product can be stored and kept at a constant temperature of —325° F. Linde Co., division of Union Carbide Co., 30 E. 42nd St., New York 17, N.Y.

655. Packaged adsorbents

Four-page guide and price list of packaged adsorbents for use in all chromatographic instruments. Listed are 28 ready-to-use partitioning agents, and 10 properly sized solid adsorbents, together with advice on the proper selection for class of sample and analysis to be made. Burrell Corp., 2223 Fifth Ave., Pittsburgh 19, Pa.

Topics Spotlights AHA Exhibits—Part II

In this special section, Hospital Topics concludes its camera tour of the technical exhibits at the annual convention of the American Hospital Association, held at the International Amphitheatre, Chicago, August 18 through 21.

Part I of the tour, which also featured some of the newest products in the hospital field, appeared on pages 81 through 88 of the September issue.

Photos by HOSPITAL TOPICS

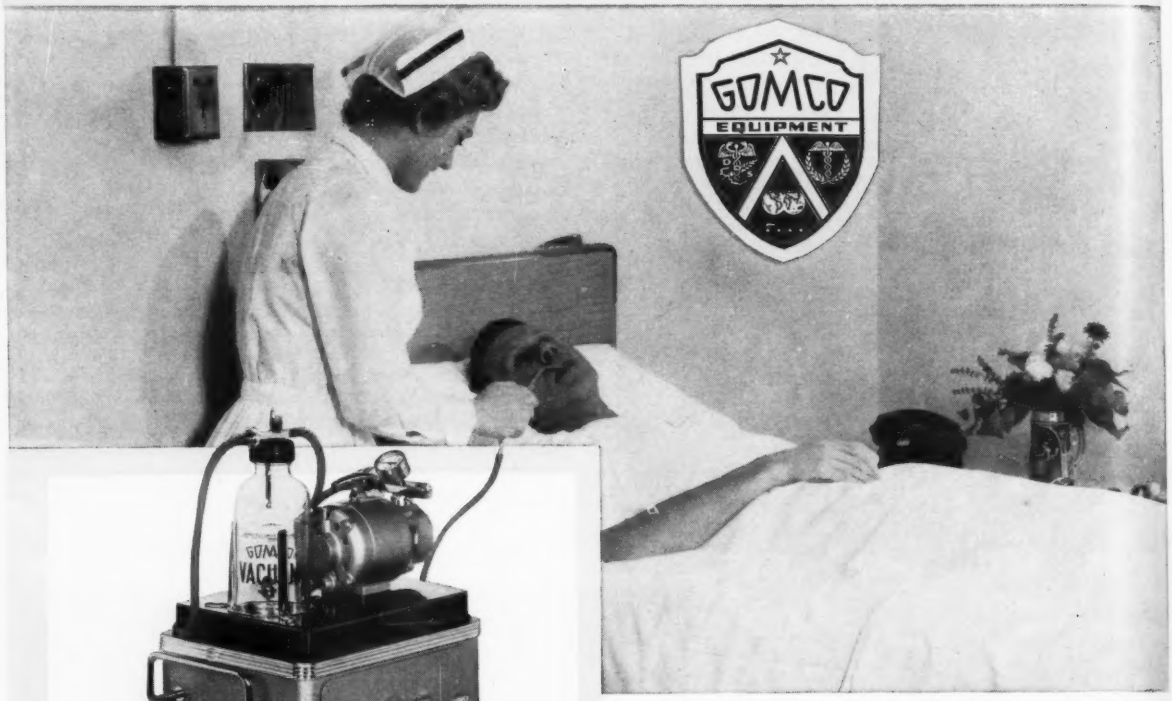
Sister Marguerite (l.), x-ray technician, and Sister Florestine, both of Lewis Memorial Maternity Hospital, Chicago, are shown the Ident-A-Band by Mary Cornell, representative of the Franklin C. Hollister Co. The sealed device carries complete identifying data, is especially valuable for checking patients before surgery, or when administering blood or medications. C-660.

E. L. Hilgers (r.), Ethicon, Inc., points out new, easy-open foil package for electron sterilized surgical gut to O. Ray Hurst, executive director, Texas Hospital Association, Dallas. The exclusive collagen pure, tru-chromized, tru-gauged properties of the product were demonstrated at the booth, which also featured needle sutures, and surgical silk and cotton. C-661.

(Continued on page 69)

True E. Read, assistant sales manager, and Doris Slosser, both of The Pioneer Rubber Co., encourage Maj. Isabelle R. Curran, Army Nurse Corps, 5th U.S. Army Headquarters, Chicago, in her own demonstration of the company's Rollpruf surgical and medical glove. Featuring flat-banded beadless cuffs which won't roll down during surgery, glove is color-banded with matching color multi-size markings. Of virgin latex which clings to the hand, the gloves are specially processed to prevent ozone cracking. C-662.

Many Uses for This Compact GOMCO Aspirating Pump



GOMCO No. 789 PORTABLE ASPIRATING PUMP

Like all Gomco equipment, the 789 is quality-built for years of trouble-free service. It is easy to clean, very simple to operate and requires a minimum of maintenance.

The lightweight Gomco No. 789 Aspirating Pump is saving valuable time and energy in thousands of hospitals and clinics from coast to coast. Weighing only 16 pounds, it is easily carried wherever the need arises.

The many important uses of the 789 include general post-operative work, removal of mucous from throats of newborn and for polio cases.

Accurate regulator valve and gauge provide precision control of suction from 0″ to 20″ of mercury. The exclusive, patented Gomco Safety Overflow Valve prevents pump damage by closing the suction system upon entry of moisture into the valve. Rubber-tired mobile stands are available if desired.

Ask your Gomco dealer to show you the many advantages of the 789 Aspirating Pump. He will be glad to demonstrate this and any of the other Gomco units in which you may be interested.

GOMCO SURGICAL MANUFACTURING CORP.

828-H E. Ferry St., Buffalo 11, N. Y.

Distributed Outside the U. S. A. and Canada by:
INTERNATIONAL GENERAL ELECTRIC COMPANY
150 East 42nd Street, New York 17, N. Y.

Ray M. Amberg, new president of the AHA, stops by the exhibit of Charles Pfizer & Co. to enjoy the refreshing atmosphere and the peaceful oriental garden, symbolic of Vistaril, the company's new tranquilizing agent. The Pfizer Medicade told the story of the development of a new antibiotic from a laboratory discovery to the doctor's prescription. Visitors made the trip through the display via one of 28 moving chairs, which traveled the circuit in five minutes. Light, color, and animation were blended in the display to illustrate the theme, "Science for the World's Well-Being." C-663.

Rosalie A. Funk, anesthetist, VA Hospital, Amarillo, Tex., is absorbed in the workings of the new plastic endotracheal tube with inflatable cuff, shown by Gerry McFarland, representative of Davol Rubber Co. Other new products featured were the Bizzarri-Guiffrida endoesophageal tube, the Dale-Schwartz rebreathing tube, and the Buyers sump drain. C-664.

(Continued on next page)

Ethelind Kirkman, hospital auxiliary, St. Francis Cardiac Guild, Roslyn, Long Island, and Joseph Keating, finance officer, Michigan Department of Mental Health, Lansing, watch as Peggy BeVier, of The Hartford Co., shows the self-closing, ropeless laundry bag featured at the exhibit. The bag, now available in quick-drying nylon, helps reduce airborne dust and lint, may be color-coded to identify contents. C-665.

Robert J. Wilkins, administrator, Immanuel Hospital, Mankato, Minn., listens as Lou Grobe, representative of Vestal, Inc., discusses the advantages of Septisol, antiseptic liquid soap. With a low pH, and only 1/50 the alkaline potential of normal soap, Septisol helps protect doctor and patient against cross-infection. Hand and wall dispensers are available for use with the antiseptic. C-666.

Fred Beach, representative of Southern Stamped Products Co., Inc., shows Marjorie Williams, nurse anesthetist, Sheridan (Mich.) Community Hospital, the stability and mobility of the Wheel-A-Chair. A dolly which converts tubular steel folding chair into a wheel chair, the device comes with 3" and 4" casters; may be purchased as a combination dolly and folding chair with rubber-tipped push handles. C-668.

Mabel O. Gordon, R.N., anesthetist, Queens Hospital, Honolulu, T.H., stops for a chat with Merle Else, representative of Physicians & Hospital Supply Co. Items for discussion included the company's new mattress cover and pillow case; narcotic box and automatic narcotic counter; Lobana body rum; Kler-Ro, hospital detergent; and Surgel lubricating jelly, all featured in the exhibit booth. C-667.

Margaret I. Lee, anesthetist, Presbyterian Hospital, Pittsburgh, Pa., is given a demonstration of the Stylex expendable hypodermic syringe by W. S. Halverson, vice-president of Pharmaseal Laboratories. Also displayed were the Sigmol non-irritating, sodium-free enema, pre-packaged in a disposable plastic container, and various pieces of expendable plastic intubation equipment. C-669.

Jess Kaufman (l.), manager, new construction division, Executone, Inc., explains some of the extensive communications systems to Bert W. Selin, administrator, and Anne J. McCorkle, assistant administrator, Bethany Methodist Hospital, Chicago, and Bert G. Hanson (r.), administrator, Memorial Hospital, Woodstock, Ill. On view were doctors' and nurses' call systems, bed occupancy and geriatric call buttons, intercom systems for nursing and administrative departments. C-670.

Gerard W. Frawley, assistant director, University of Minnesota Hospitals, Minneapolis, receives a sample of Dermassage from Mark Baskin, representative, S. M. Edison Chemical Co. An emollient, medicated skin lotion containing no alcohol, Dermassage helps control bed sores and sheet burn. Greaseless, it cools and lubricates the skin with natural menthol, hypo-allergenic lanolin and olive oil, retains its homogenous state even after prolonged storage. Comes in plastic and glass containers. C-671.

(Continued on next page)

A. W. McMahon (l.) and Robert N. Murray, representatives of Woodlets, Inc., join forces to describe the hospital uses of Ozium to Walter C. Richards, assistant administrator, Sarnia (Ont., Canada) General Hospital. The glycol-ized air conditioner comes in new personal size as well as larger institutional dispenser. C-672.

C. C. Pratt, owner, Pratt Hospital Equipment Co., demonstrates surgery and recovery room collection outfit double, with positive pressure, to Sister M. Domicile (l.), anesthetist, and Sister N. Bernadette, supervisor, St. Mary of Nazareth Hospital, Chicago. Exhibit featured the company's complete line of operating and recovery room suction equipment, portable ward suction machines, plus a new recovery room wheeled stretcher. C-673.

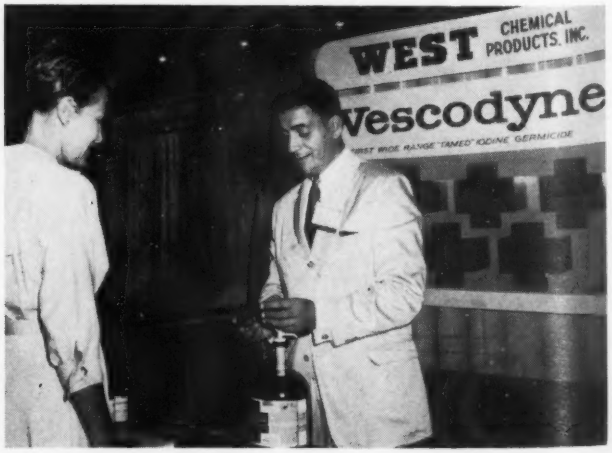
Charles W. Colin, Shampaine Co. representative, points out the advantages of the Hampton obstetrical delivery table to Sister Mary Virgil Koch (l.), nurse anesthetist, and Sister M. Arthur Schramm, both of Sacred Heart Hospital, Yankton, S. Dak. Shampaine exhibit also showed autoclaves, and line of food service equipment, including the stainless steel super meal cart. C-674.

Pearle Keiserman, R.N., Scholl Mfg. Co., shows Harold F. Falknor, chief engineer, Grant Hospital, Chicago, how Tubegauz adapts itself to hard-to-bandage areas. The seamless tubular gauze can be washed and autoclaved without losing its special characteristics. Samuel Frome, Scholl representative, waits in the background to demonstrate the special applicators that are used to mold Tubegauz to areas to be bandaged. C-675.

(Continued on page 74)

A demonstration of O.E.M. Corporation's new automatic Mechanaire is given by Frank Feagan, O.E.M., for Inez C. Brock, St. Margaret's Hospital, Montgomery, Ala., and president of the Association of Nurse Anesthetists. The device, for oxygen tent therapy, automatically controls and maintains the pre-set oxygen concentration, the flow of oxygen being adjusted for loss due to canopy leaks, opening of zippers. C-676.

Rosamond Schroms, nurse anesthetist, St. Mary Hospital, Manhattan, Kans., learns more about the hospital applications of Wescodyne from David R. Peck, director of technical advisory service, West Chemical Products, Inc. A detergent-germicide containing tamed iodine, Wescodyne is nonselective in its action against pathogens. C-677.



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INCERT provides a sterile, safe, single-step "closed system" method of adding a variety of medications to solutions. The **INCERT** vial, left in position in the solution bottle, identifies the medication until ready for use.

Here is a real economy in lighter work-load and reduced preparation costs . . . ready for instant use in your hospital.

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NOW AVAILABLE IN INCERT®

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INCERT T41—Thiamine HCl 25 mg., Riboflavin 10 mg., Niacinamide 100 mg., Sodium Pantothenate 20 mg., Pyridoxine HCl 20 mg., Ascorbic Acid 500 mg.
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VI-CERT® (Lyophilized B Vitamins with Vitamin C).
INCERT T16—500 mg. lyophilized succinylcholine chloride.
INCERT T17—1000 mg. lyophilized succinylcholine chloride.

SUCCINYLCHOLINE CHLORIDE

SUX-CERT (Lyophilized succinylcholine chloride for skeletal muscle relaxation).
INCERT T110—500 mg. in 5 cc. sterile solution.
INCERT T140—1000 mg. chloride in 10 cc. sterile solution.

POTASSIUM CHLORIDE SOLUTION

INCERT T2010—20 mEq K+ and Cl– in 10 cc. sterile solution (2 mEq/cc.).
INCERT T2030—30 mEq K+ and Cl– in 12.5 cc. sterile solution (2.2 mEq/cc.).
INCERT T2020—40 mEq K+ and Cl– in 12.5 cc. sterile solution (3.2 mEq/cc.).

POTASSIUM PHOSPHATE SOLUTION

INCERT T31—(1.579 gm. K_2HPO_4 and 1.639 gm. KH_2PO_4 per 10 cc.). Contains 30 mEq K+ and HPO_4= in 10 cc. sterile solution.

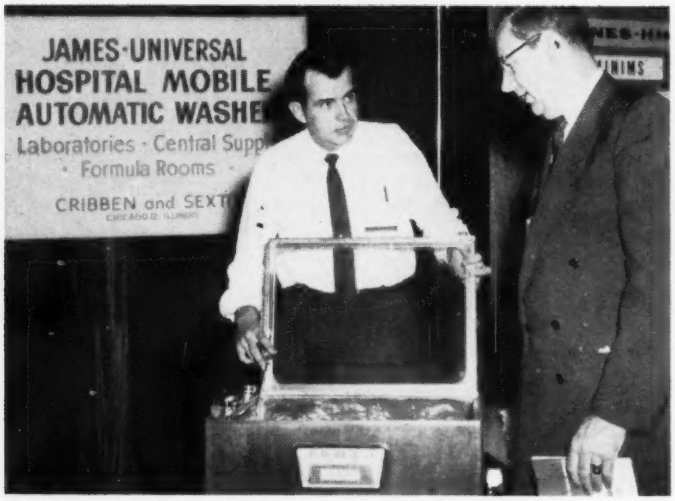
CALCIUM LEVULINATE SOLUTION

INCERT T51—10% solution, 1.0 gm. (6.5 mEq of Calcium) in 10 cc. sterile solution.

TRAVENOL LABORATORIES, INC.
Morton Grove, Illinois

pharmaceutical products division of
BAXTER LABORATORIES, INC.

B. Witt, representative of Ciba Pharmaceutical Products, Inc., describes some of his company's services to Francis G. Zanke, anesthetist, Deaconess Hospital, Freeport, Ill., while W. Segwick and Gerald Johnson, both of Ciba, mentally check off the points, including availability of Netter books and slides, film library available to hospitals, materials to aid in nursing education. C-678.



Dean Henry, representative of Cribben & Sexton Co., demonstrates the James-Universal mobile automatic washer to Martin H. Albrecht, superintendent, University Hospital, Madison, Wis. The washer, for syringes and glassware, is fully automatic, requires no special installation. It operates on a 14½-minute cycle, washing 500 syringes, 32 nursing bottles, or 1,000 test tubes. Uses patented walking-wall-of-water action, automatic detergent dispenser. Stainless steel construction. C-679.

Patricia McNally, R.N., and Irene Ottolino, R.N., both of St. Anne's Hospital, Chicago, watch the technic of using new control syringes demonstrated by Maurice Cherbo, representative of Eisele & Co. The exhibit also featured the company's line of regular and interchangeable hypodermic needles, for which separate parts are available when breakage occurs. C-680.

Ampifilter, Mead Johnson's constantly closed infusion system, is the subject of representative Ed Gode's talk with James L. Lyons, assistant administrator, Memorial Hospital, Houston, Tex. A protective measure against cross-infection, Ampifilter prevents contaminated air from coming into contact with the solution at any time. C-681.

The Pharmacy

Formulary, New Product Reference Provide Tools for Pharmacist

• Two publications scheduled for release this month will provide useful tools for the hospital pharmacist and, in addition, will help him make an active contribution to the drug therapy program of his institution.

One is *The American Hospital Formulary*, compiled and published by the American Society of Hospital Pharmacists. A subscription service, *The Formulary* will supply standardized drug monographs and supplemental information tailored for hospital use and adaptable to the needs of individual institutions.

The other publication, also a subscription service, will make available monthly reference sheets on new products. Tentatively titled *Pharmacopedia*, the service will be introduced by Skyline Publishers, Portland, Ore.

Formulary Service

The Formulary will provide drug monographs in loose-leaf form and will issue supplementary monographs at regular intervals. Designed to eliminate the costly, time-consuming task of compiling an individual hospital formulary, it will enable the pharmacy and therapeutics committee to select for inclusion in the loose-leaf binder the drugs the medical staff considers most useful and necessary for the specific needs of the hospital.

The monographs are being prepared by William M. Heller, Ph.D., chief pharmacist, University of Arkansas Medical Center, Little Rock, and chairman of the ASHP committee on pharmacy and pharmaceuticals. Assisting him is Marc Jordin, Ph.D., head, department of pharmacology, University of Arkansas School of Pharmacy, Little Rock.

The monographs may be used for reference by physicians and nurses as well as pharmacists since dosage forms and amounts, routes of administration, side effects and toxicity, and unusual procedures or

(Continued on page 77)

Revolving Wheel Expands Pharmacy Storage Area

A revolving "drug wheel" has helped solve the problem of limited storage space in the pharmacy at Baptist Memorial Hospital, Memphis, Tenn.

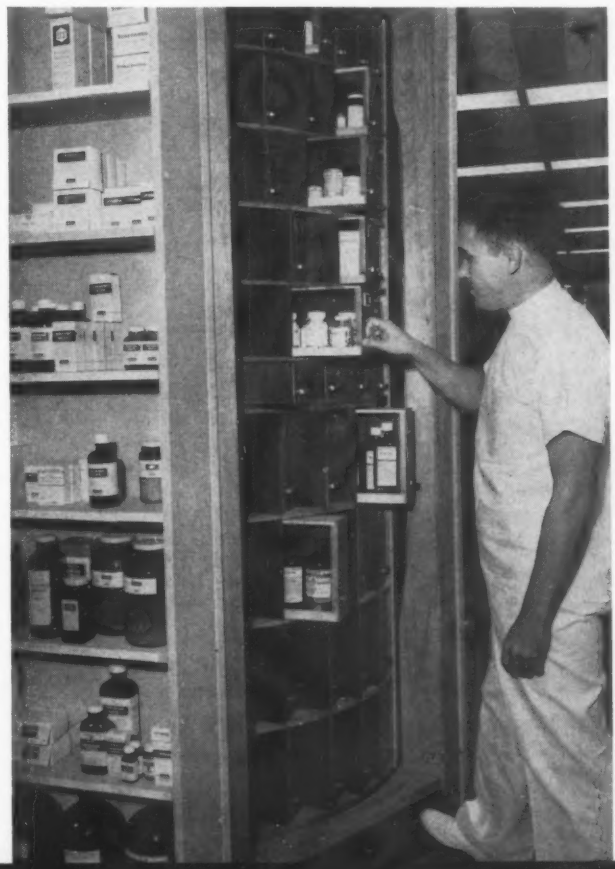
According to Grover C. Bowles, Jr., director of the hospital's pharmacy service, the wheel* provided an ideal answer to the need for more shelf area in the department. Infrequently used items are stored on the wheel, freeing open shelving in the pharmacy for the supplies needed more often.

Stretching from floor to ceiling, the wheel, enclosed in a natural wood cabinet, occupies only five square feet, but provides storage space equal to 600 linear feet of 10-inch shelving. Constructed of wood, it is said to be capable of supporting two tons.

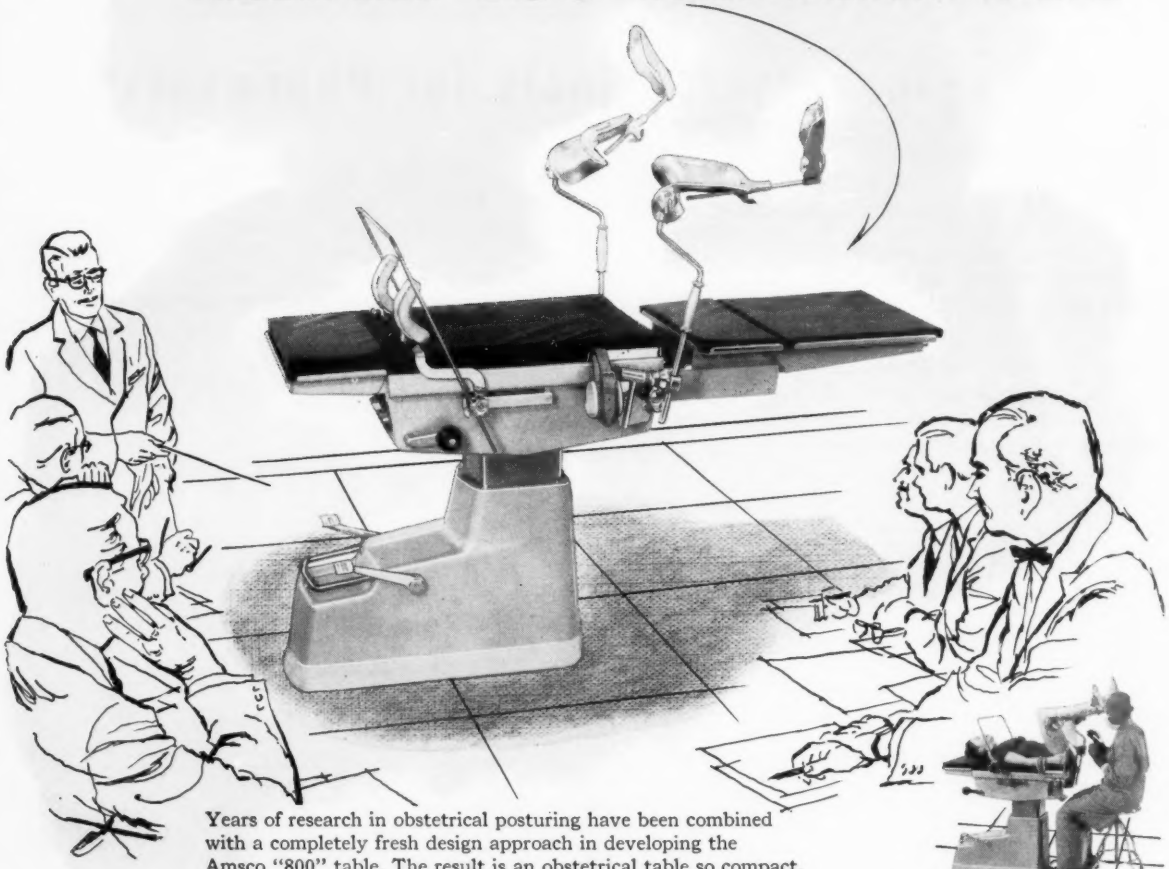
The wheel is equipped with shelves, spaced at varying heights. Pull-out drawers, partially open on one side, fit between the shelves. These vary in width as well as depth, giving an efficient range for storage of different-sized items. Each drawer is numbered to simplify indexing.

A foot brake controls the turning of the wheel, so that it may be stopped at the desired drawer. In the Baptist pharmacy, the wheel is placed adjoining the open shelf area, allowing easy stock handling.

*Manufactured by the Bailey Planing Mill, Columbia, Mo.



Presenting THE ALL NEW AMERICAN "800" OBSTETRICAL TABLE



Years of research in obstetrical posturing have been combined with a completely fresh design approach in developing the Amsco "800" table. The result is an obstetrical table so compact, so maneuverable and so efficient as to be truly revolutionary in its advantages for operative as well as perineal route delivery.

From the narrow, flowing lines of the flexible top to the *permanent* or *portable* power base . . . the "800" is *new*.

Excellent delivery approach

Every Feature

- **finger-tip controls**
- **retractable foot section**
- **retractable 12" delivery shelf**
- **ratchet type legholder sockets**
- **flexible head and foot sections**
- **wide perineal opening for postpartum drainage**

. . . each is new, exclusive and vital to the convenience of the obstetrician and the welfare of the patient.

Maneuverable table top

Every hospital and every obstetrician will have a direct interest in this dramatically better table. Fully illustrated brochure TC-224-R is available without obligation.

Unobstructed surgical approach

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

World's largest designer and manufacturer of Sterilizers, Operating Tables, Lights and related hospital equipment

THE PHARMACY

(Continued from page 75)

precautions necessary in administration are listed for each drug.

Prepared for arrangement by pharmacologic action and therapeutic use, the monographs are headed by the nonproprietary name of the drug. Included are common synonyms, trade names, a brief description of the actions and uses of the agent, and, when pertinent, comments on its stability, solubility, and other factors. Monographs may also be filed alphabetically if preferred.

Also available in *The Formulary* is supplementary information on poison antidotes, prescription writing, biochemical and conversion tables, and generally accepted rules and regulations for pharmacy and therapeutics committees.

The cost of the subscription service, which includes the drug monographs, a loose-leaf binder, and supplementary monographs for one year, is: One to nine copies, $15 each; 10 to 24 copies, $14.50 each; 25 or more copies, $14 each. *The American Hospital Formulary* may be ordered from the American Society of Hospital Pharmacists, The Hamilton Press, Hamilton, Ill.

New Product Reference

Pharmacopedia will offer monthly, printed references on all new products released since its preceding issue. Information will be put on approximately a 2-week basis with a mid-monthly, unindexed supplement.

Heading Skyline Publishers, a new company, is William C. Felter, former editor and publisher of the *Pacific Drug Review*.

Each reference issued will describe the formula, chemistry, indications, contraindications, administration, dosage form, packaging, and price for the product. Therapeutic, trade-name, manufacturer, and generic-name indexes will be cumulative for the current issue and the 11 preceding issues. A ring binder, distributed with the subscription, will hold 12 issues.

The subscription service is available, at $18 a year, from Skyline Publishers, P. O. Box 1029, Portland, Ore.

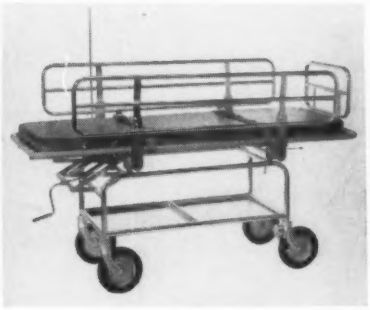
AEC Grants $9,000 To College of Pharmacy

The Atomic Energy Commission has granted $9,000 to the University of Illinois College of Pharmacy for training students in the handling of radioisotopes.

The funds will be used to buy equipment for an educational and training program designed to teach students, particularly those majoring in hospital pharmacy, how to dispense and assay radioactive materials, and to understand the health problems involved in the handling and disposing of such materials.

NEW RECOVERY ROOM STRETCHER CAT. No. RS-100

COMPARE IN YOUR OWN HOSPITAL



SPECIFICATIONS: (optional)
Length 76½"
Width 29½"
Height 34"

MATTRESS:
25" x 75" x 3"
Foam Rubber.
Cover—(Harco #4626) Conductive.

SAFETY STRAP:
2" Nylon.

SIDE RAILS:
Pratt all position retractable.
Automatic lock any position.
Rails completely out of the way when down.
5 to 6 inches more space available for the patient when using these rails with the conventional size mattress.

HEAD SECTION:
Hydraulically operated.

HEAD RAIL: Removable.

CASTERS:
2-lock, 2-swivel—10 inch x 2¼ inch.
Conductive. Balloon-tires.

ADJUSTABLE HEAD REST.

IV HANGER: Adjustable.
Can be placed in 8 positions around table.

SHOULDER REST. ARM BOARD. LOWER TRAY FOR BLANKETS AND ACCESSORY STORAGE.

FRAME:
1¼" 16 gauge steel tube helio-arc welded. Entire frame Chrome plated. Top stretcher frame reinforced with 1¼" 16 gauge steel tube.

STRETCHER BOTTOM AND LOWER STORAGE SHELF:
20 gauge stainless steel.

The design, construction and finish of this stretcher, makes it the sturdiest, best appearing and most practical all around recovery room unit available. It will pay you to write for our special introductory offer for trial and inspection in your own hospital.

30-DAY FREE TRIAL
(Freight Prepaid)

PRATT HOSPITAL EQUIPMENT MFG. CO. 3007 SOUTHWEST DRIVE LOS ANGELES 43, CALIF.

prescription pad

Anticholinergic—Tranquilizer

Pro-Banthine with Dartal is recommended for gastrointestinal disturbances in which there is prominent emotional or anxiety overlay.

The G. D. Searle & Co. drug contains 15 mg. Pro-Banthine, brand of propantheline bromide, providing anticholinergic action, and 5 mg. Dartal dihydrochloride, brand of thiopropazate dihydrochloride, for tranquilizing activity.

Tablets are available in bottles of 100 and 500.

Oral Nasal Decongestant

Burroughs Wellcome & Co. has introduced Fedrazil, an orally administered nasal decongestant and bronchodilator with antihistaminic action.

Each tablet contains 30 mg. Sudafed, brand of pseudoephedrine hydrochloride, and 25 mg. Perazil, brand of chlorcyclizine hydrochloride. Sugar-coated tablets are supplied in bottles of 100.

Lotion for Psoriasis

Alphosyl lotion, marketed by Reed & Carnrick, is for treatment of psoriasis.

The cream-colored lotion contains allantoin and selected coal tars in a vanishing cream base. Advantages listed by the manufacturer include nonirritability, safety, lack of greasiness or staining.

Alphosyl comes in clear glass bottles of 8 fl. oz. each.

Antidepression Agent

Riker Laboratories has introduced Deaner for treatment of simple depression, nervous exhaustion, periodic headaches, and chronic fatigue states.

It is the para-acetamidobenzoic acid salt of 2-dimethylaminoethanol, and has the generic name, Deanol. Clinical studies have not revealed incidence of sensitization or habituation.

Deaner is supplied in tablets of 25 mg. each.

New Dosage Forms

Azotrex syrup has been introduced for combined sulfonamide-tetracycline treatment of urinary tract infections. It is marketed by Bristol Laboratories.

Each teaspoonful (5 cc.) contains 125 mg. of tetracycline activity and 250 mg. sulfamethizole. It is available in 4-oz. bottles. Azotrex is also available in capsule form.

* * *

Lorfan tartrate has been introduced by Roche Laboratories, division of Hoffmann-La Roche, Inc., in 1-cc. ampuls containing .05 mg./cc., for treatment of narcotic-induced respiratory depression in the newborn. The ampuls are available in boxes of 6 and 25 and can be administered by subcutaneous, intramuscular, or intravenous injection.

* * *

Repetabs are new product form of Trilafon, tranquilizing and antiemetic agent, manufactured by Schering Corp. Each Repetab contains 8 mg. of perphenazine, in two 4-mg. cores separated by a timed barrier coating. Available in bottles of 30 and 100.

Everybody's talking about Staph...

. . . and with good reason. Staph is a *real* trouble maker. Staphylococcus aureus—to be more formal—is vicious. It invades every part of the hospital. Wherever there are people, it can multiply. In dust, staph lives for weeks waiting to re-infect.

Once staph gets on the loose, there's no telling where it may turn up next . . . operating rooms . . . nurseries . . . patient rooms . . . laundry . . . food service. Among insidious troubles it can cause are postoperative wound infection . . . staphylococcal pyoderma . . . puerperal mastitis . . . staphylococcal pneumonia and enterocolitis.

(Editor's note: In fact, staph infection can pave the way for strep infection, too. If strep gets into a wound with antibiotic-resistant staph . . . parenteral penicillin won't stop or prevent strep infection even when the strep organisms are penicillin sensitive.)

Stopping staph troubles—or never letting them start—that's the problem. Careful attention to *total* environmental asepsis. . . critical evaluation of disinfection procedures and the disinfectants used . . . is an important part of the answer.

Take Lehn & Fink disinfectants, for instance. All four—Lysol®, O-syl®, Amphyl® and Tergisyl™ (new detergent-disinfectant)—kill even antibiotic-resistant staph. Besides being staphylocidal, they kill all pathogenic organisms . . . including fungi and TB bacilli . . . commonly known to cause cross infection in hospitals.

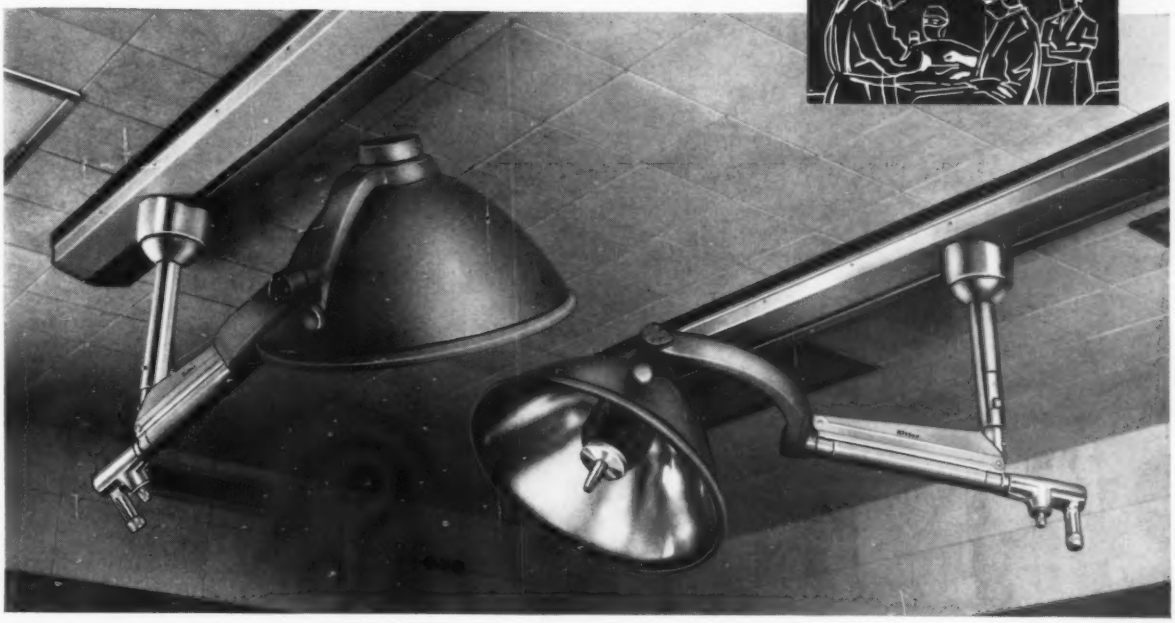
Let us show you how to use our disinfectants to control the spread of staph. Won't you write us at 445 Park Avenue, New York 22, N. Y.?

Professional Division
Lehn & Fink Products Corporation

THE NEW

RITTER TWIN-LIGHT

FOR MAJOR SURGERY!



OPTIMUM SHADOW REDUCTION... FULL-RANGE FOCAL DEPTH

The new Ritter Twin-Light for major surgery offers these important advantages:

- Minimum heat with totally enclosed dual filters.
- Intensity control.
- Illumination 2500 to 10,000 foot-candles.
- Color correction: 4000° Kelvin.
- Snap-on sterile handles permit surgeon to adjust light beam.
- Two separate light beams greatly aid in simultaneous operative work at adjacent anatomical sites.
- Sterile handle permits surgeon to control focal adjustment of light pattern ranging from large 10-inch field to small spot. Provision is also made for circulating nurse to make these adjustments.

The suspension system of the new Ritter Twin-Light incorporates these outstanding features:

- Entirely new type of track reduces dust dispersal to a minimum, not possible with conventional exposed tracks. Dust-filtered optical system.
- Tracks may also be flush-mounted with ceiling, and thus out of sight, dependent on type and ceiling height.
- All electrical wiring and moving parts concealed in single arm reflector yoke.
- No counterweight.

Medical-Hospital Division of

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THE RITTER COMPANY, INC.

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Please send us full information on Surgery and OB Lights.

☐ We are renovating our surgeries.
☐ We are building.

Name of consultant .....

Name of architect .....

Name of hospital .....

Signature.....

Position.....

Address.....

City.....State.....

"Now-at last!

we've found a cleaner made especially for surgical instruments. *It's wonderful!"*

Free Weck Cleaner is one of the Weck Specialties for the handling and processing of syringes, needles, catheters, instruments, etc. for Central Supply Service. Weck has prepared a special 8-page brochure which fully explains and illustrates this revolutionary new system. For your copy, just write to Weck.

OF COURSE IT'S WONDERFUL!

It's the *only* instrument cleaner made by an instrument manufacturer.

Weck Cleaner not only cleans more effectively, but it actually *goes twice as far!* You need only ½ ounce—instead of the usual one ounce—to the gallon. One 5 lb. can makes 160 gallons of cleaning solution. This, *by actual hospital test,* is enough to clean 36,000 instruments, or all the instruments needed in 565 average operations. An entire laparotomy set costs less than 1¢ to clean with this "miracle" cleaner. The special "penetrating" action of Weck Cleaner removes all soils from metal and glass by soaking—no scrubbing is needed—yet Weck Cleaner will not corrode metal, etch glass or deteriorate rubber, and is completely safe for hands. Weck Cleaner is also ideally suited for use in the new ultrasonic washers.

Send for FREE sample of WECK Cleaner

WECK

68 years of knowing how

EDWARD WECK & CO., INC. 135 Johnson Street, Brooklyn 1, N. Y.

WECK

Manufacturers of Surgical Instruments • Hospital Supplies • Instrument Repairing

THE LAB

Blood Bank Technic*

By Carl W. Walter, M.D.†

• In 1840 Richard Oliver published a classic description of a case of uterine hemorrhage in which blood transfusion was successfully employed:

"Blanched by profuse hemorrhage, which no adequate means had been employed to suppress, but which had now ceased, she was lying on her back in a state of imperfect consciousness, with the pulse at her wrist barely perceptible . . . deceitful promises of reaction were succeeded by progressive indications of sinking . . . I was provided with the apparatus necessary for performing transfusion; and having obtained willing supply of blood from three of the patient's kind-hearted neighbors, I opened a vein at the bend of the elbow . . . we had the very perfect gratification of witnessing not only the complete restoration of the circulatory power, but the return of consciousness."[1]

It is obvious that Oliver was fortunate that the kind-hearted neighbors unwittingly donated compatible blood. It is obvious that he transfused enough fresh blood to substitute for that lost by the hemorrhage. It is paradoxical that a century of technical progress has improved the availability and quantity rather than the quality of blood used in blood banks.

The freshly drawn blood transfused by Oliver differed markedly from the blood infused into almost all patients today. His patient received blood in which the cells were a living population with a normal life expectancy. All the senescent cells had been scavenged by the donor's reticuloendothelial system. Erythrocytes, platelets, and leukocytes present in the donor's blood retained their functional capacity and effectively restored the red cell mass and bolstered the clotting mechanism. About one percent of the donor's cells became senescent daily and were scavenged. The youngest of the infused cells disappeared from the recipient's circulation three to four months after the transfusion.

Contrast this with blood supplied by blood bank technic. Senescence of the red cells proceeds in the refrigerator at the same rate as *in vivo*. As the cell population ages, an increasing percentage of erythrocytes irreversibly deteriorates. When the blood is infused both viable cells and superannuated cells are thrust into the patient's circulation. The latter are removed rapidly even during the infusion. The freed hemoglobin may be a distinct liability to the patient with peripheral vasoconstriction and renal ischemia. To others, the deficit in viable cells may necessitate five infusions to accomplish the repair usually expected after three transfusions of fresh blood. Blood degrades in other ways too complex for consideration here. The discriminating clinician, therefore, has learned to choose his blood collection technic to fit the individual patient's need for a specific kind of blood rather than to accept any container of compatible blood proffered by the blood bank. The modern blood bank provides at least ten products to satisfy distinct clinical needs.

The first of these is whole blood drawn from the donor and infused into the patient with minimal delay. Modern technic of blood collection removes the factor of common site and time of collection and infusion typical of the direct blood transfusion. The

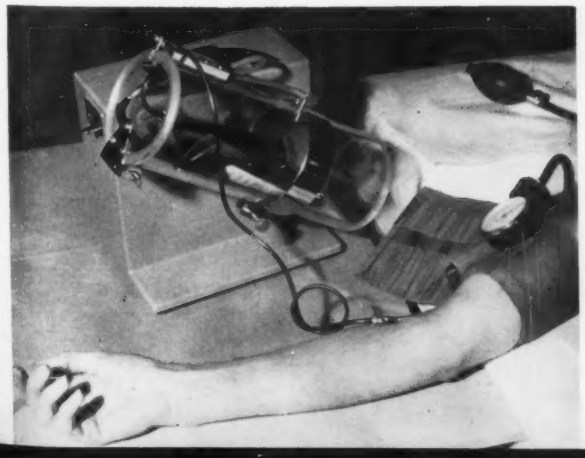
(Continued on next page)

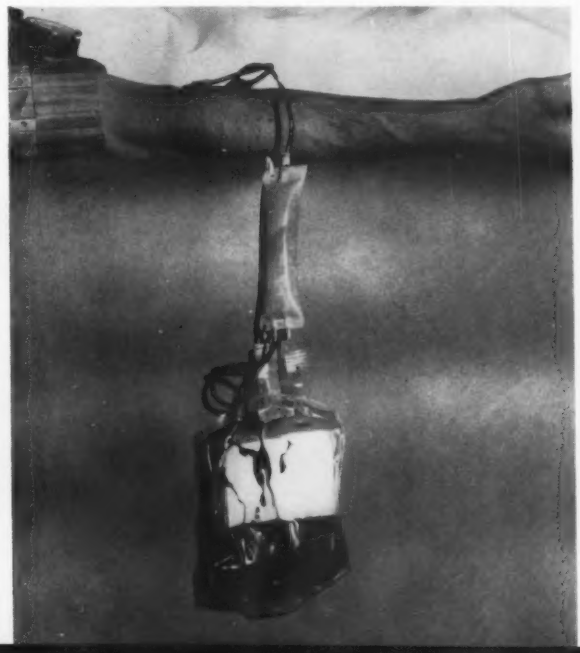
*Reprinted with permission from *Health News*, 35:4-9 (February, 1958).

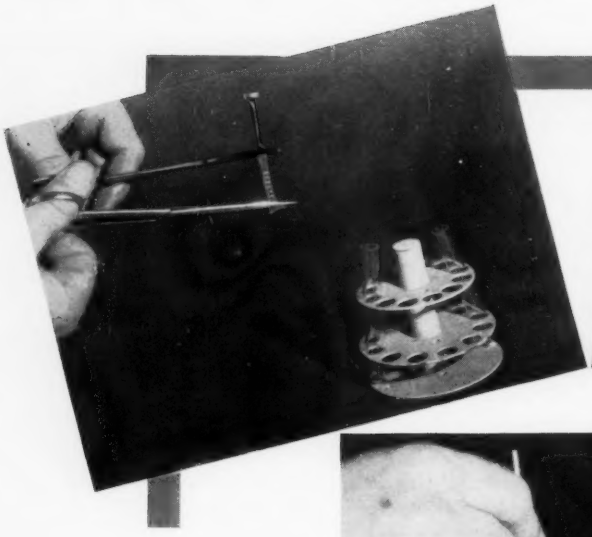
†Director, Blood Bank, Peter Bent Brigham Hospital, Boston; associate clinical professor of surgery, Harvard Medical School, Boston.

Right: Collection of blood through an ion exchange column prevents clotting by removal of calcium. The blood is unadulterated by anticoagulant nutrient solution.

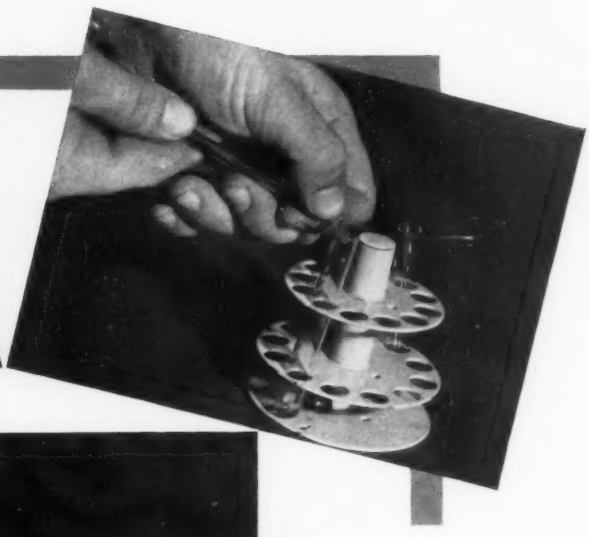
Below: Automatic rocker simultaneously applies mild negative pressure to the blood pack to hasten collection.



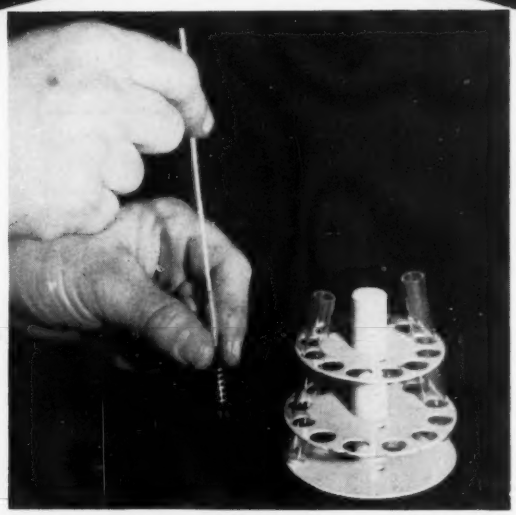




Centrifuged numbered aliquot for cross-matching is cut open with scissors when needed.

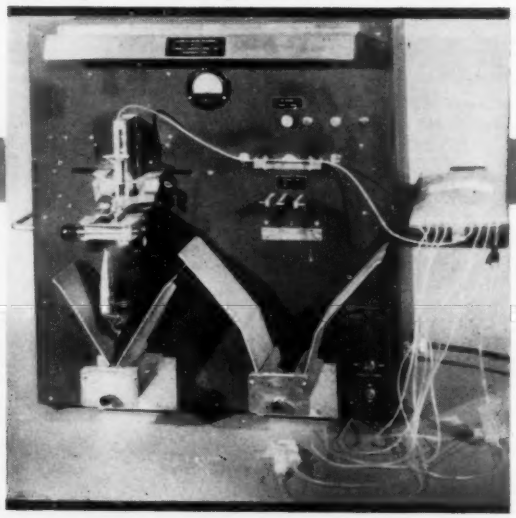


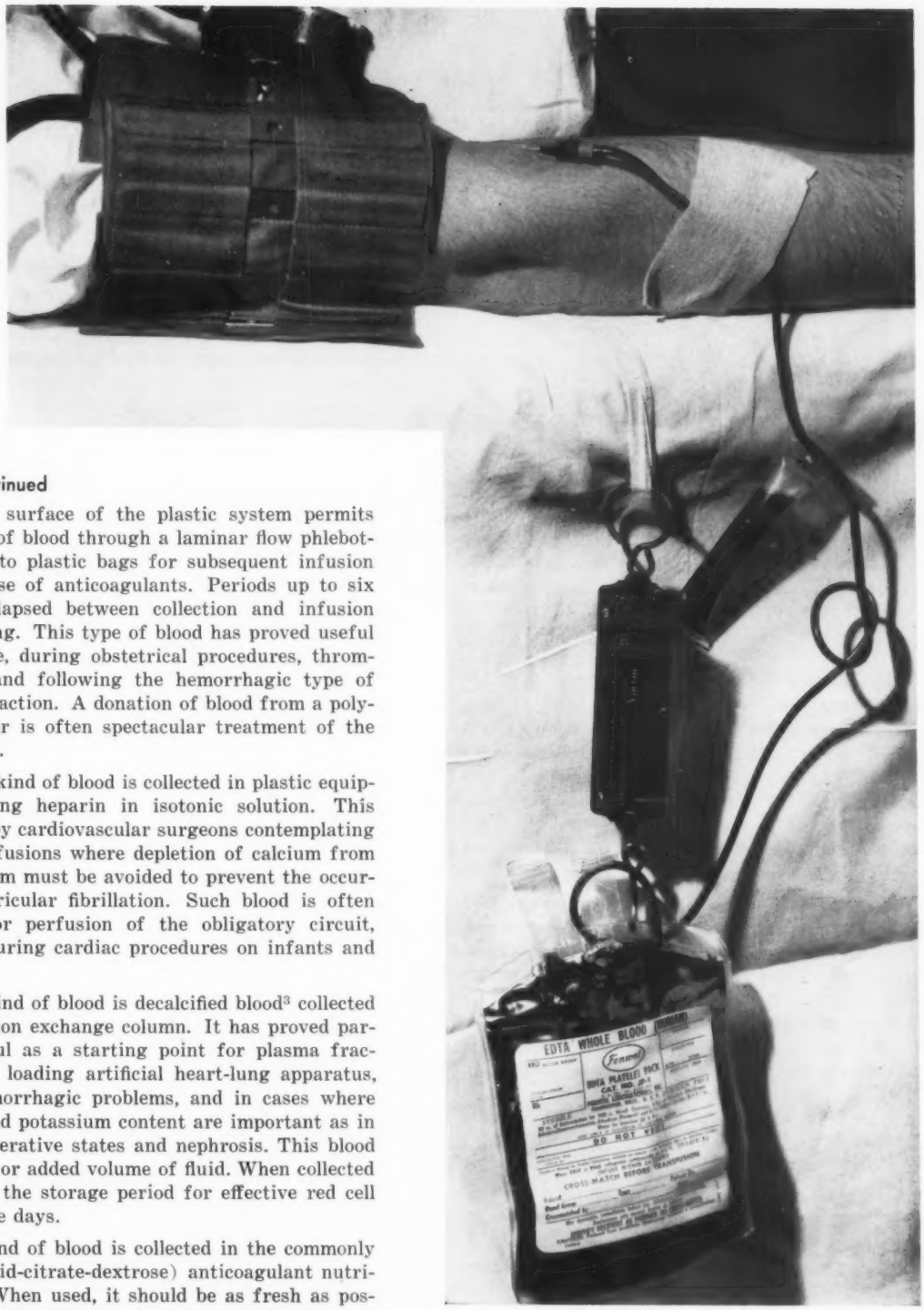
Clamp applied at interface permits expression of plasma by rolling tube on clamp.



Above: Red cells may be removed on an applicator stick or a drop of them may be squeezed into saline to make the suspension commonly used.

Below: Automated plasma expression is achieved by hanging a blood pack on fingers of a machine that simultaneously opens the protector sheaths about delivery tube and a transfer pack coupler, and plugs coupler into delivery tube. Flow of plasma is controlled by platens and is checked by a photoelectric cell. Blood pack and transfer tube are then hermetically sealed so that components can be cut apart without danger of bacterial contamination.





For platelet transfusion the initial flow of blood is collected in a side pouch by manipulation of bead valves in the collecting tube to trap tissue juice picked up in the needle. The blood in the pouch can be used as a pilot sample for typing, grouping, and serology. This technic is used by some banks for ACD (acid-citrate-dextrose) collection when large aliquots are needed.

hemorepellant surface of the plastic system permits the collection of blood through a laminar flow phlebotomy needle into plastic bags for subsequent infusion without the use of anticoagulants. Periods up to six hours have elapsed between collection and infusion without clotting. This type of blood has proved useful in hemorrhage, during obstetrical procedures, thrombocytopenia, and following the hemorrhagic type of transfusion reaction. A donation of blood from a polycythemic donor is often spectacular treatment of the latter problem.

The second kind of blood is collected in plastic equipment containing heparin in isotonic solution. This blood is used by cardiovascular surgeons contemplating massive transfusions where depletion of calcium from the myocardium must be avoided to prevent the occurrence of ventricular fibrillation. Such blood is often oxygenated for perfusion of the obligatory circuit, particularly during cardiac procedures on infants and children.[2]

The third kind of blood is decalcified blood[3] collected through a cation exchange column. It has proved particularly useful as a starting point for plasma fractionation, for loading artificial heart-lung apparatus, for many hemorrhagic problems, and in cases where low sodium and potassium content are important as in certain postoperative states and nephrosis. This blood has no citrate or added volume of fluid. When collected into dextrose, the storage period for effective red cell viability is five days.

A fourth kind of blood is collected in the commonly used ACD (acid-citrate-dextrose) anticoagulant nutrient solution. When used, it should be as fresh as possible although its infusion is safe and effective for three-quarters of the transfusion problems up to 21 days and under emergency conditions for 28 days. Post-infusion survival rate of red cells refrigerated at 5° C. for 21 days ranges from 65 to 75 percent in glass containers, and from 85 to 90 percent in plastic.[4] Remembering always that as the medical resources of the community are diluted through paucity of supplies

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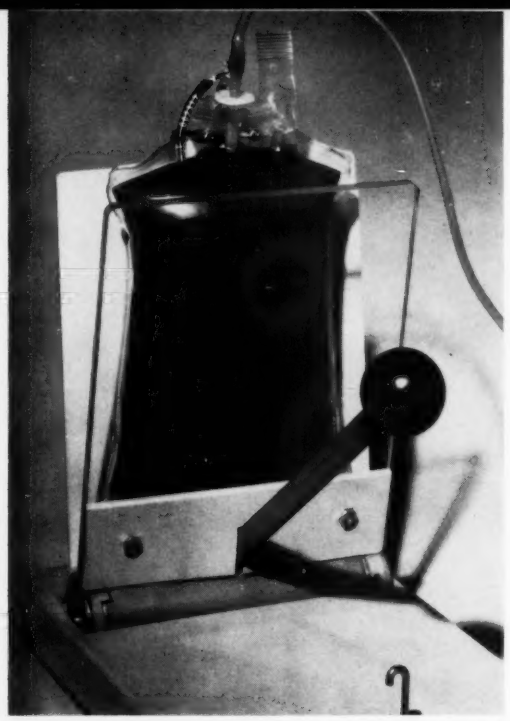

Simple press expresses plasma from a blood pack in which cells have sedimented or have been packed by the process of centrifugation.

or overwhelming casualties, ideal therapy is also abandoned in the effort to control mass morbidity and mortality. Older blood is used under these circumstances. This should be avoided, however, in civilian practice dedicated to the care of the individual, particularly in severe shock, burns, crush injuries, and when multiple infusions are contemplated, because the free hemoglobin may damage ischemic renal tissue.

A fifth blood product consists of red cells. When collected in plastic equipment the red cells remain fluid and can be infused without resuspension. Longevity of the red cell is comparable to the ACD from which it was separated.[5] This permits maximal additions to the patient's red cell mass with but half the fluid volume, minimal increase in oncotic power, and elimination of 75 percent of the sodium content of ACD blood. Patients with low cardiac reserve, chronic anemia, depleted states, and the nephritides benefit from this technic.

A sixth product is platelets. Blood is drawn into ethylene-diamine tetraacetic acid (EDTA), a chelating agent that sequesters the calcium, much as does citrate, and also prevents the platelets from sticking together. Several types of plastic equipment are available for separation of platelets from the red cells by differential centrifugation.[6] The platelets can be infused in the form of platelet-bearing plasma.

The seventh blood product, concentrated platelets, is prepared in the blood bank by careful centrifugation of freshly separated plasma.[7] The supernatant plasma is removed leaving a small pellet of platelets to be infused for control of thrombocytopenic problems.

The eighth blood bank product is freshly frozen plasma for the control of hemorrhage in hemophilia.

The ninth product is plasma. This is separated from centrifuged blood and stored at room temperature for six months to destroy the virus of homologous serum jaundice.[8] Following culture to establish its sterility, it has value because of its oncotic power and nutritional components. Individual units of type specific plasma are easiest to process. Small pools—eight or 10 units of plasma—are safely managed, particularly when the entire pool is destined for use by a single recipient.

The tenth product of the blood bank, and one that is too often forgotten, is albumin. Plasma salvaged from outdated blood or from blood drawn from donors whose medical history contraindicates the use of the blood directly in the care of the recipient can be converted to albumin. During the chemical process involved, the disease-bearing portions of the plasma are discarded and the heat-sterilized albumin is available to restore oncotic power in the recipient.

At this point a warning is indicated. There is a definite risk involved with every transfusion. Hemolytic reactions still occur because of errors in labeling, confusion of pilot tubes, infusion of the wrong bottle of blood, and lack of observation of patients during the infusion. Any untoward reaction is an indication to stop infusion immediately. Clinical evidence may be the first sign of sensitization to sub-groups and rare blood groups by previous transfusions. Infected blood causes death just as spectacularly as transfusions may save life. The mortality rate for transfusions is higher than that for appendicitis or ether anesthesia. Of 3,000 transfusion deaths in 1953, 10 percent resulted from technical errors; 90 percent were due to faulty identification of recipients.[9] Late morbidity due to homologous serum jaundice is an undetectable hazard. Accordingly, there must be a positive indication for every transfusion.

Modern blood bank practice eliminates much of the hazard of transfusion by providing better quality blood collected by a technic whereby there is positive identification of blood samples and pre-infusion culture of each unit of blood is feasible. Plastic equipment has been designed to provide the types of blood indicated by the clinical needs. It insures maintenance of asepsis and safe storage. Foolproof identification of pilot aliquots for typing, grouping, cross-matching, and culture is designed into the technic. The new equipment increases the stability of the blood and makes infusion more effective in that it can be accomplished at the rate and in the quantity determined by the clinician in charge of the patient.[10]

The new technic also affords the donor benefits. Syncope, with its apprehension, perspiration, nausea, and often prolonged weakness, is a major deterrent to many donors. Slow withdrawal of blood into the plastic equipment permits compensation for the change in blood volume due to phlebotomy, and donor reactions are minimal. The fact that the plastic bag contains only liquid is positive assurance that air embolism, a real hazard recognized by experienced phlebotomists, cannot occur.

(Continued on page 86)

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(Continued from page 84)

The advantages of processing blood in plastic equipment begin in the donor room. Collection of an accurate quantity of blood is accomplished by hanging the plastic bag on a spring scale. Continuous attendance during phlebotomy can be avoided by using an automatic cut-off device that occludes the donor tube when the proper quantity of blood has been collected. In busy donor rooms it is convenient to use a rocker in which the collection bag is enclosed in a vacuum chamber where the blood is agitated to mix it with the anticoagulant. Five inches water-negative pressure is applied to hasten bleeding. This device also shuts off when the phlebotomy is complete.

The task of grouping, typing, and cross-matching is made easy by the integral donor tube. This tube is permanently attached to the blood pack to retain its identity and is numbered at intervals so that identifiable segments can be cut free for use of aliquots.

After phlebotomy is accomplished, the lower bead is squeezed to permit blood to flow into the donor tube as far as the side pouch. The upper bead is then squeezed to divert blood into the side pouch. When the pouch is full, the lower bead is milked into the bag to open a channel for the collection of blood. When enough blood has been collected the single throw knot is pulled tight to seal the donor tube.

The needle is then removed from the vein and inserted into a "Vacutainer." Enough blood for serological determination is transferred into the "Vacutainer" by squeezing the upper bead. The residual blood in the side pouch can be sealed by knotting the tube close to the needle.

Samples for grouping and typing can be obtained by centrifuging the side pouch to separate the serum. The top is nicked to permit serum to be expressed. Saline suspension is then added to pick up cells.

The whole blood in the donor tube is stripped into the bag by drawing the tube between the thumb and a metal object, beginning at the knot and proceeding until the entire donor tube is collapsed. When the tube is released, ACD blood refluxes.

Fresh aliquots for culturing[10] or cross-matching can be obtained by restripping the tube at any time during storage and isolating the distal segment with knots, a metal clip, or a dielectric sealer. The isolated segment is then cut free. It can be centrifuged to pack the cells in one end. A clip is then placed across the segment at the plasma cell interface and a corner is cut from each end of the segment so that either fluid can be squeezed out, dropper fashion.

Plastic blood packs can be centrifuged in the conventional 500-cc. trunion cups. One or two packs are placed in a cup and water is added to support the packs. The top speed on the centrifuge can be used without damage to the packs. The result is firmly packed red cells and a clear supernatant plasma.

The plasma can be expressed from the blood pack by means of a closed system so that the packed cells are not contaminated. This can be accomplished manually by suspending the pack connector of a transfer pack and squeezing the plasma into the latter. A spring press is available to accomplish this more readily.

For mass processing, automatic equipment is available that mechanically connects the plastic transfer pack or pooling pack automatically and cuts off the flow when the red cell interface passes a photoelectric eye.

The same device also subdivides blood donation for pediatric transfusions. This technic permits safe division of the blood for multiple or serial transfusions with no danger of bacterial contamination.

From the discussion it is apparent that the choice of plastic equipment for blood transfusion implies the exploitation of a complete system for processing blood in the blood bank that eliminates hazards of loss of identity and contamination while it permits preparation of blood products needed by the individual patient.

The logistic advantages of plastic equipment for military purposes are obvious. Blood banks and hospitals have not appreciated the saving in storage space and the increase in refrigerator capacity inherent in the shift to plastic containers that save 83 percent of the space when unfilled and 50 percent when full of blood. Plastic bags with ACD weigh 19.4 percent of glass. Full of blood, they weigh but 50 percent. Plastic packs with integral donor tubes require no storage space or handling for the latter.

The infusion of blood from blood packs is easy and reliable. Specially designed recipient sets provide an adequate channel for blood to reach the nylon filter. Slowdown and stoppage are eliminated. Positive pressure infusion is accomplished either by squeezing the blood pack or by sliding it into a pressure pouch and building pressure in a rubber bladder to squeeze the blood from the plastic container.

The modern blood bank can easily supply the specific needs of the individual patient for blood and its components, utilizing revolutionary technics for collection, processing, storage, and infusion of blood. Better blood, safer, simplified technic, and controlled infusion are additional benefits to the patient.

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Pediatrics

Diagnosis of Neonatal Jaundice, Treatment of Erythroblastosis Discussed at AMA Pediatrics Session

• *This month TOPICS continues the abstracts of selected papers presented before the Pediatrics Section of the American Medical Association at its meeting in San Francisco. Additional abstracts from this meeting were carried in the September issue, page 100. See the August issue, pages 26-30 and 33-40, for other convention news.*

Serum Transaminase Measurements May Aid In Diagnosis of Neonatal Jaundice

Various Unit Levels Found For Different Conditions

Serial measurements of serum transaminase activity appear to be valuable aids in the etiological diagnosis of neonatal jaundice.

In addition, information derived from such measurements may serve as a guide to therapy. Thus it may permit early operative intervention in surgically amenable types of neonatal biliary obstruction prior to the development of appreciable irreversible hepatocellular damage. Also it may help prevent unnecessary surgical intervention in other types of neonatal jaundice.

Studies of normal newborn term infants in the first week of life revealed that levels of activity up to about 120 units for serum glutamic-oxalacetic transaminase and levels up to about 90 units for serum glutamic-pyruvic transaminase may be considered physiologic for the early neonatal period.

A study of patients with neonatal jaundice caused by pathological conditions gave us distinctive patterns of enzyme activity. In neonatal jaundice associated with infection, normal physiologic levels of enzyme activity were maintained. In jaundice caused by hemolytic conditions, GO-T and GP-T activity usually remained within the physiologic neonatal range. However, in an acute fulminating form of hemolysis the activity of GO-T alone was temporarily increased up to levels of about 300 units.

In neonatal biliary obstruction (both inspissated bile syndrome and extrahepatic) serum enzyme activity increased slowly to a peak below 800 units and then leveled off at a lower range. In the inspissated bile syndrome the progressive increase began more abruptly in the early neonatal period. In atresia or agenesis of bile ducts, the increase in activity began later.

In jaundice resulting from acute hepatitis, there was a rapid increase in serum enzyme activity during the stage of increasing hyperbilirubinemia, and a sharp fall thereafter. The peak activity for one or both enzymes was above 800 units—higher than that found in neonatal jaundice from any other cause.

Our studies involved a limited number of patients. Further studies are necessary to test our generalizations.—*Simon Kove, M.D., Stanley Goldstein, M.D.,* and *Felix Wroblewski, M.D.,* department of pediatrics, New York University College of Medicine; children's medical service, Bellevue Hospital; and the division of metabolism and enzyme studies of Sloan-Kettering Institute and the department of medicine, Memorial Center for Cancer and Allied Diseases, New York City.

Recommend Treating Erythroblastosis In the Community Hospital

Delay in Transfer May Be Dangerous; Necessary Facilities, Personnel Listed

Babies with erythroblastosis fetalis can and should be managed in the community hospitals in which they are born, provided adequate laboratory facilities are available.

The only hope in the difficult problem of treatment of a baby with hydrops, at present, seems to lie in an immediate exchange transfusion, followed by a second within three to four hours, without consuming time in transfer to another hospital.

Until recently, management of babies with erythroblastosis has been undertaken almost entirely by large teaching hospitals, which have served as referral centers. It has thus been necessary to give certain instructions to local hospitals regarding care of the cord, blood samples, and so forth, prior to their transporting the infants to the treatment center. The time consumed in transfer has sometimes interfered with optimum treatment.

The most important major requirement for effective management of these babies in a community hospital is co-ordinated teamwork (with 24-hour availability of all concerned) among the obstetrician, the attending pediatrician, the pediatricians on the exchange transfusion team, and personnel in the diagnostic laboratory,

(Continued on next page)

the blood bank, and the nursery and delivery room. Elimination of wasted time may be lifesaving.

The minimum laboratory technics required are not numerous and usually are available in most hospitals. One must be able to determine the maternal blood group, the Rh factor, and the anti-Rh titer. To substantiate a diagnosis of suspected Rh incompatibility at birth, or to diagnose Rh or ABO incompatibility in babies with jaundice during the first 24 hours or undue jaundice during the first five days, one must be able to perform a Coombs test and to determine the baby's blood group, Rh factor, hemoglobin, and serum direct and indirect bilirubin levels.

The facilities and instruments necessary for exchange transfusion are available in any hospital. They include a few simple surgical instruments, sterile polyethylene catheters, 10 percent calcium gluconate solution, Witebsky (A and B) substance, and available donors of type O, Rh-negative blood.

Adjuvant requirements for effective transfusion therapy and for follow-up care include oxygen, facilities for warming the infant, antibiotics, digitalis, and cortisone.

The actual performance of an exchange transfusion requires a certain amount of technical skill. However, the experience of doing some replacement transfusions is now almost inevitably included in a residency in pediatrics. In our hospital we believe it advisable to have all babies with erythroblastosis or suspected erythroblastosis followed by a small group of pediatricians and transfused by them.

All babies with a suspected diagnosis of this disease are seen, transfused if necessary, and followed by one or more of the five members of the exchange transfusion team, which has been an organized group of practicing pediatricians since 1952. The pediatric resident or attending pediatrician also follows these cases.

From October, 1954, through September, 1956, there were 111 babies with erythroblastosis in 14,908 live births. Seven of these were stillborn. Sixty-one of the 104 live-born babies required exchange transfusions. There were six deaths among the 104 babies. The overall mortality rate, therefore, was 5.8 percent.—*Maurice Adelman, M.D., D. W. J. Bell, M.D., Frank Guinta, M.D., John T. Barrett, M.D., Leonard B. Bellin, M.D.,* and *Ruth Appleton, M.D.,* Providence (R.I.) Lying-In Hospital.

Upper Arm Block Called Safe Method of Regional Anesthesia

Effective in 79 of 80 Cases Studied; Useful in Fractures in Children

Upper arm block by the axillary route is an excellent, safe method of regional anesthesia. It has been especially useful in the treatment of recent fractures in children. In such cases, one may assume there is food in the child's stomach, and thus there is the risk of aspiration under general anesthesia.

In 80 consecutive cases in which we used the method, there was only one in which the block was not effective. This case was an open reduction of a supracondylar fracture. The reason for failure is not clear.

Seventy-two of the 80 were 10 years of age and under. The youngest patient was six weeks of age, and had markedly displaced fractures of the radius and ulna.

We have used two percent Xylocaine with 1:100,000 epinephrine in most of these cases. The average volume of drug used was 10 cc. The smallest volume was 1.5 cc., in the 6-week-old baby.

The technic is simple. Children have not objected to the technical needling, and have co-operated well.—*Mack L. Clayton, M.D.,* and *Donald A. Turner, M.D.,* Denver, Colo.

Meprobamate Used to Control Spasms in Tetanus Patients

Not Effective in Seizures Induced by Internal Stimuli

Spasms of tetanus which are evoked by external stimuli can be controlled completely by the use of injectable meprobamate.

After injection of this drug, noises, jarring, or sticking with a pin, all of which would cause a severe spasm in the ordinary tetanus patient, do not have any seizure-inducing effect.

Meprobamate has no effect, however, on seizures induced by internal stimuli. Thus, if the patient is turned, or if his tracheal tube is cleaned out, he will have a seizure. The use of meprobamate has made it possible to care for these patients while they are still conscious and able to communicate.

If a patient continues to have seizures after he has been given the drug, the physician should assume that they are being triggered by visceral discomfort. Relief of fecal impaction, a distended bladder, or a blocked tracheal tube may often be necessary. Because the patient does not have to be totally depressed, it is possible to unmask these visceral symptoms, and easier to localize them.

Since we have started using this drug, we have discontinued the use of curarizing drugs with mechanical respirators. As a result, the nursing problem and the morbidity have been reduced.

At one time, most of the tetanus patients in the Chicago area were either newborn infants who had navel infections or individuals who had suffered penetrating wounds. At the present time, however, the tetanus population is composed primarily of heroin addicts, who often develop tetanus not only because they use unsanitary equipment for injections, but also because many heroin peddlers have been using house dust as an adulterant.

Since tetanus is physiologically almost identical with the syndrome of strychnine poisoning, it is likely that meprobamate would be the drug of choice for strychnine poisoning.—*Meyer A. Perlstein, M.D.,* associate professor of pediatrics, Northwestern University Medical School, Chicago.

a plan of attack

against the spread of infections in hospitals

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Today it is *staphylococcus aureus* 52/42B/81 and other uncontrolled resistant strains. These organisms are producing serious infection in patients, newborn infants and hospital staff.

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There is only one apparent effective control: *complete disinfection throughout the hospital.*

It must be continual—there must be a return to the "old fashioned" hospital attitude and methods of asepsis. No longer can we let antibiotics substitute for the tried and true methods of cleanliness.

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(Continued from page 24)

A maximum of eight hours' use of this type of ventilation was set for our patients until safe tolerance for longer periods could be proved.—*William D. Loeser, M.D.*, medical director, respiratory and rehabilitation center of the University of Buffalo (N.Y.) Chronic Disease Research Institute.

Pilot Study Attempts to Evaluate Cold Wet-Sheet Envelopment Therapy

Find Variations in Pulse Rate, Rorschach Responses

In selected psychiatric patients, we believe that properly administered cold wet-sheet enevelopment can make an important therapeutic contribution, despite the fact that, as a result of recent advances in the management of psychiatric patients, this form of treatment has reached its lowest ebb.

Although hydrotherapy has been used for almost a century in our psychiatric hospitals, there is a conspicuous paucity of controlled studies of physiologic and psychologic effects of cold wet-sheet envelopment. In our pilot study, 15 subjects and 15 controls were selected from a group of hospital employees and students. The subjects were enveloped in cold wet sheets; the controls were covered with dry sheets.

In addition to evaluating such physiologic functions as pulse, respiration, blood pressure, systemic temperature, and skin temperature, we gave subjects and controls modified psychological tests before and at the conclusion of the testing situation. A record was made of other objective changes and subjective experiences. Especially noteworthy results were variations in the pulse rate and Rorschach movement responses.—*Jack Meislin, M.D.*, chief, physical medicine and rehabilitation service, and *Henry Stano, B.S.*, chief physical therapist, both of VA Hospital, Montrose, N. Y.; and *Jerome L. Singer, Ph.D.*, research associate, Institute of Psychological Research, Teachers College, Columbia University, New York City.

Reports Success with New Approach To Treatment of Whiplash Injuries

A new approach to the treatment of whiplash injuries has been used with good results in 56 patients during the last 18 months. Most of the patients were severely involved, yet only one required hospitalization. An average of 13.8 treatments per patient was required to alleviate or completely relieve symptoms.

The method consists of a program of manual mobilization and manually applied traction therapy preceded by some form of moist heat and either ultrasound or microtherm therapy. Rhythmic, gentle exercises are prescribed initially to the ranges of motion still actively present. These are gradually lengthened.

After the first treatment, there is increase in range of motion and some decrease in pain and stiffness. The patient is then instructed in mild rotating exercises to be done three to four times a day in order to preserve the newly acquired range of motion. Muscle relaxants are also prescribed, but analgesics are rarely required.

The oft-encountered whiplash headache has also been found to clear rapidly with this regimen.— *David Rubin, M.D.*, instructor in physical medicine, University of Southern California School of Medicine, Los Angeles.

Surgery Relieves Joint Pain, Improves Mobility in Arthritis, Osteoarthritis

No Morbidity, Mortality in 12 Unselected Patients

Extended lumbar sympathectomy has been used with good results in 12 unselected patients with advanced rheumatoid arthritis and osteoarthritis of the hip and/or knee joint.

No morbidity or mortality resulted in this group of middle-aged and elderly patients. In the immediate postoperative period, patients exhibited remarkably effective, consistent, and lasting relief of joint pain, with concomitant improvement in joint mobility and in general functional capacity.

The patients have been followed for periods up to three years postoperatively. In all instances, the relief of joint pain and improved mobility have persisted.—*Robert Herfort, M.D.*, attending surgeon, Grasslands Hospital, Valhalla, N.Y., and *S. Harold Nickerson, M.D.*, director of orthopedics, St. Agnes Hospital, White Plains, N.Y.

Tell 80% Success in Treating Bursitis With Short-Wave Electrical Energy

Over 80 percent success was obtained with the use of pulsed short-wave electrical energy in the treatment of 50 bursitis patients with calcium deposits.

In acute attacks, pain was usually relieved in the first week of treatment, and it disappeared completely in two weeks. Normal motion was restored in two to four weeks, and calcium deposits, where known, disappeared in eight to 10 weeks.

In the treatment, more than 1,300 watts of instantaneous power is available to the patient. The pulses are so timed that the elevation of temperature during the pulse is dissipated.—*Abraham J. Ginsberg, M.D.*, formerly associate in physical medicine, Hospital for Joint Diseases, New York City.

Ultrasonic Therapy Used To Remove Plantar Warts

Patients Have Had No Recurrences

Ultrasonic therapy proved a successful method for removing plantar warts in eight of nine patients treated.

Mineral oil was applied to the warts, which were then exposed to ultrasound waves for 15 minutes. None of the patients complained of heat effects or pain. When the wart had been extremely painful, almost complete relief was obtained after the first five minutes. Number of treatments varied from one to 11.

There have been no recurrences, although insufficient time has elapsed for ascertaining a "cure."

When more than one wart is present, or when x-ray or certain local applications have been used, the response to ultrasound seems to be impaired.—*Herbert Kent, M.D.*, associate professor, department of physical medicine, University of Oklahoma School of Medicine and University Hospitals, Oklahoma City.

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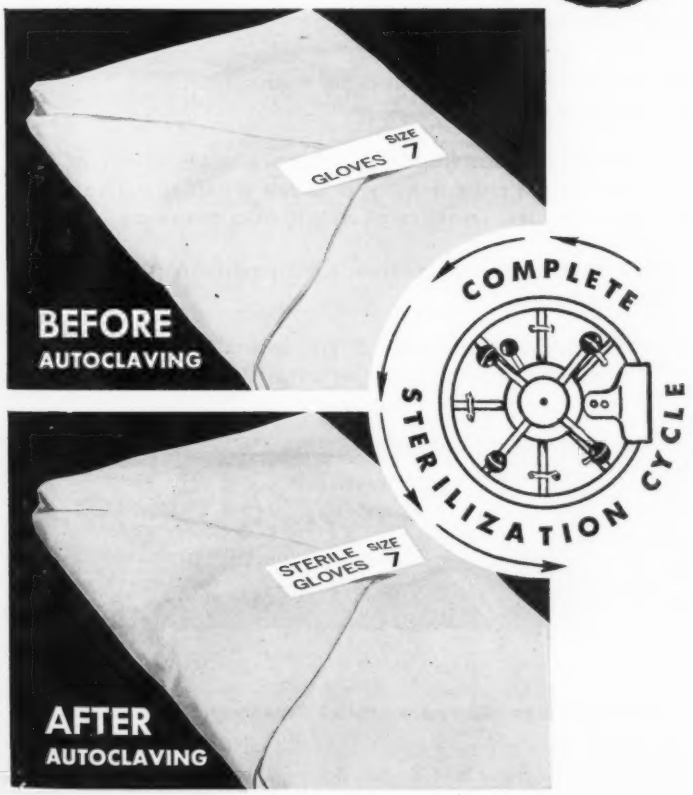

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1. Grossman, L.: Archives of Pediatrics, 71: 173—179, June 1954.

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Breast Feeding in the United States: Extent and Possible Trend*

A Survey of 1,904 Hospitals with Two and a Quarter Million Births in 1956

By Herman F. Meyer, M.D.†

VARIED opinions, often based on local data and observations, have been expressed as to the increase or decrease of breast feeding in the United States. In 1948 Bain[1] reported the results of the first comprehensive survey as to the incidence of breast feeding in this country and stated: "The question of trend still remains unanswered. Later studies will be needed to show increase or decrease of breast feeding."

The study presented here after a 10-year interval is an initial effort in the direction of indicating a possible trend. The extent of breast feeding in 1,904 hospitals including 2¼ million hospital-born infants in 1956 is recorded, and these data are compared to those of Bain in the appended tables. By state and by geographic regions, there are fewer infants breast-fed at the time of discharge from the hospital than there were 10 years ago.

PREVIOUS STUDIES

Medical literature is replete with individual opinions and local reports as to the extent and duration of breast feeding in other countries as well as in the United States. In an excellent review of this literature, containing markedly varying opinions and data, by Jackson *et al.*,[2] one may find 32 references on this subject appearing as recently as 1945 to 1954.

The only study which covered all sections of the United States at relatively the same time was that of Bain[1] made in 1946 and 1947, and reported in 1948. It was conducted as part of a comprehensive study of child health services and pediatric education.[3] Among many related data, this survey collected information on various facets of maternity nursery care, including the incidence of breast, mixed and bottle feeding during a one-week period of 1946 or 1947. The returns comprised 72 percent of 3,500 hospitals of 25 maternity beds, and an actual count of the number of infants discharged (39,171) was made during a specified week.

From these observations it was found that for the United States as a whole, one-third of the newborn infants were receiving artificial milk mixtures on discharge from the hospital, and that two-thirds were breast-fed or received mixed feedings (breast and artificial feeding). A smaller percentage of breast feeding occurred in urban and suburban hospitals as contrasted with hospitals in areas removed from metropolitan centers. A lower percentage of breast feeding obtained in medium-sized hospitals (100 to 299 beds), as differentiated from small (25 to 99 beds), and large (250 or more beds) hospitals. Striking regional differences were noted: In the Northeast, 61 percent of infants were receiving artificial feeding in contrast to 18 percent in the Southwest and Southeast.

PLAN OF THE PRESENT SURVEY

A questionnaire was submitted to each of the nursery supervisors of the 2,981 hospitals in which there were 300 or more infants born, according to the statistical listings for 1955.[4] There were 1,904 (63.9 percent) questionnaires returned (Table I, page 96). In this study the question was asked as to the types of feeding the infant was receiving on discharge from the maternity nursery, i.e., the *percentage* discharged with breast feeding only, with mixed feeding, or with artificial feeding only. In Bain's survey the exact *number* of infants receiving each of the specified feedings in a given week was recorded and the percentages calculated. Thus only the *percentages* in these two studies can be compared.

RESULTS

In all of the geographic regions (Table II, page 96) and in each of the states [Table III—omitted] there were more infants leaving the hospital maternity nurseries with artificial feeding than there were 10 years ago. The Northeast led in the number of artificially fed newborn infants (79 percent), as was the case 10 years previously (61 percent). The Southwest had the least number artificially fed (50 percent), as was true a decade ago (18 percent). The state of Mississippi had the greatest increase of artificial feeding—from 14 percent 10 years ago to 74 percent at present. Tennessee, Arizona and New Mexico had the lowest incidence of artificial feeding, and Massachusetts, Connecticut

(Continued on next page)

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†Northwestern University Medical School, and Children's Memorial Hospital, Chicago.

TABLE I

Proportion of Hospitals Reporting on Type of Infant Feeding on Discharge from Hospital Maternity Nursery

United States	Total Hospitals		Reporting Hospitals			
			Number		Percent	
	1946*	1956†	1946*	1956†	1946*	1956†
	3,500	2,981	2,513	1,733	72	58
Regions:						
Northeast	523	438	363	244	69	56
East and Central	990	927	633	588	67	63
Southeast	744	634	598	321	80	51
Southwest	293	241	243	134	83	57
Mountain and Plains	583	448	397	324	68	72
Pacific	367	293	249	178	68	61

*Hospitals of 25 or more beds which accept women for delivery (Bain[1]).
†Hospitals with 300 or more annual births (taken from American Hospital Association Report[4]).

and Maine the highest. In the survey of 10 years ago, South Carolina and Alabama had the lowest percentages of artificial feeding while the highest were Connecticut and New Hampshire. As may be seen in Table II, 35 percent of the infants of the country as a whole in Bain's survey left the hospital with artificial feeding entirely, while in the present survey the percentage was 63.

Factors in the Maternity Nursery Influencing Breast Feeding

An effort was made to have those answering the questionnaires state whether efforts were made in their specific hospitals which influenced breast feeding. Of the 1,889 hospitals reporting, 78 percent stated that some effort was made to stimulate such an influence or interest (Table IV). It was the consensus of the contributors that many primiparous mothers could be influenced to try to nurse their infants if given encouragement. Those with much clinical experience in this field are of the opinion that the extent of breast feeding in any given hospital is in proportion to the enthusiasm of the attending personnel.[5,6]

Age of Discharge from Maternity Nursery

In Bain's report, 58 percent of the infants were discharged under eight days of age, and these infants had a higher incidence of breast feeding (41 percent) as compared with those discharged after eight days

(Continued on page 98)

TABLE IV

Effort Made to Urge Mothers to Nurse Infants

	Hospitals Reporting
Yes	1,469
No	420
Effort made by:	
Nursing staff	1,003
Obstetrician	1,053
Pediatrician	571
Others	139

TABLE II

Percent of Infants Receiving Specified Feeding at Time of Discharge from Hospitals in 1946 and 1956 (by Geographic Regions)

United States	Breast Only		Breast and Bottle		Bottle Only	
	1946*	1956†	1946*	1956†	1946*	1956†
	38	21	27	16	35	63
Regions:						
Northeast	23	12	16	9	61	79
East and Central	36	20	30	15	34	65
Southeast	55	27	27	16	18	57
Southwest	47	27	35	23	18	50
Mountain and Plains	44	26	28	17	28	57
Pacific	31	25	29	19	40	56

*Bain's data.[1]
†Calculated average percent based on yearly census of infants born in hospitals.[4]

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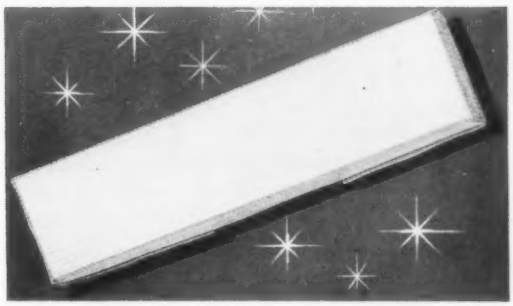

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(Continued from page 96)

(35 percent). The observation was made that the babies discharged earlier than eight days were less apt to have been weaned at the time of discharge than those who stayed longer.

In Table V it is shown that most newborn infants in 1956 left the hospital at five days of age or under (84 percent), the usual age being four or five days. There may be a relationship between early discharge of the mother and infant and the failure to breast feed. Those who deal with the problem of breast feeding clinically have the impression that the early discharge from the nursery currently in vogue lessens the chance of continuing breast feeding. The mammary glands reach their postpartum engorgement about the fourth or fifth day after the infant's birth, when lactation is just beginning. This is the time when exodus from the hospital to the home most often occurs, with exigencies of the transition becoming factors in insecurity and emotional instability of the mother.

TABLE V

Average Age When Infants Leave Hospital

Age (Days)	*Hospitals Reporting*
2	28
3	244
4	488
5	877
6	181
7	63
Later	23
	1,904

Hill[7] and other authorities interested in the factors influencing breast feeding, fear this is an important reason why more mothers have little success with breast feeding in modern times. There are no data, but only individual impressions as to the continuation of breast feeding by these mothers, nor any statistics which might be compared to the era when the postpartum hospital period was 10 days or longer, as was current 25 years ago.

COMMENTS

From the earliest records of man, the need for breast feeding of his young has been pre-eminent in the struggle of man with his environment. In paintings, sculpture, literature, music and other art forms, nursing of infants has been held as a high virtue. The stimulus of this artistic expression was probably expedience, since this mode of nurture stood between the attrition or perpetuation of a tribe, race or even species. Its need was known to all of the rovers and conquerors along the Mare Nostrum who held high the value of a captured slave who was a potential wet nurse. There is Gibbon's grim reminder that he places prominently on the list of causes of the fall of the Roman Empire the early dissolution of that civilization when the nursing of the young became unfashionable. Through song and story, each generation of mothers and mothers-to-be has been exhorted to breast feed their progeny, and in both lay and medical literature the modern mothers are reminded that this ancient practice is still an important requirement of successful motherhood.

With the advancement of chemistry, bacteriology, and physiology, as well as with the increase of many accoutrements incident to the modern standard of living, other substitutes for human milk were found which were nutritionally as adequate and more con-

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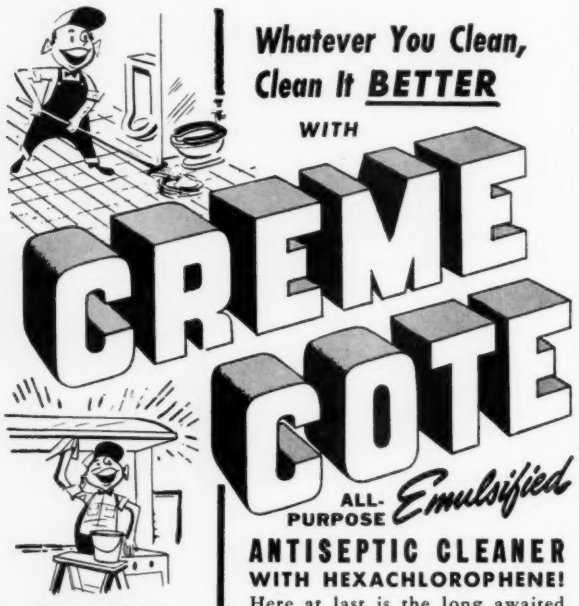

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stantly available. Some now find themselves in the paradoxical situation of extolling *breast feeding* as a practice, while others raise doubts concerning human milk as the "perfect nutrient."

In a symposium on "Milk in Relation to Human Nutrition,"[8] a few of the questions raised were as follows: Do antibodies transmitted in human milk withstand digestion and enter the infant's blood stream? What of the variability of some of the constituents in human milk, such as the ratio of the various amino acids, the assortment of unsaturated fatty acids, and the over-all concentration of minerals? What are the specific virtues of the disaccharide lactose in human milk as opposed to other sugars used in infant feeding? Is the small proportion of casein and the larger ratio of lactalbumin found in human milk an advantage over the reverse situation found in milk from other mammals? What of the well-known lack of the specific nutrients (vitamins D and C) in this so-called perfect food?

MILK NOT PERFECT

Holt[8] expressed the opinion that he did not disparage human milk, and that by and large it was an excellent food, but it was not to be worshipped as the perfect food—"the fact that a substance is found in breast milk does not constitute proof that it is a nutrient." He also added that our knowledge as to the requirements of human nutrition is far from complete and is still a challenge for more cautious and careful investigation.

The protagonists of breast feeding from a cultural viewpoint are of the opinion that many of the problems originating from the exigencies of our present social order can be best met by prevention. This program, they infer, should begin at birth. Rooming-in, emphasis on breast feeding, later use of self-demand feeding, and a less authoritative attitude toward infants and children are all fundamental precepts in neutralizing some of the tensions of modern society.

Breast feeding, if carried on willingly by the mother, adds to the security of the infant and contributes satisfaction as well as a sense of "being needed" to the mother. These are said to be attributes which are of help in promoting a calm environment for ideal infant care.

CONCLUSIONS

The percent of infants in the United States leaving hospital maternity nurseries with breast feeding decreased from 38 percent, in 1946, to 21 percent in 1956. There is evidence in each category of states and regions of the United States that there is less breast feeding of hospital newborn infants than there was a decade ago. If confirmed 10 or 20 years hence by comparable surveys, it could be said that a *trend* existed toward less breast feeding in this country. The presented data suggest an *inclination* or *slant* toward that direction.

The results of statistical data shown in the two surveys discussed in this report, and the results anticipated in future surveys, are a reflection of an important change in our cultural pattern. Any variation either way in the incidence of the ancient practice of breast feeding of newborn infants is anthropologically important in regard to the culture of the present time.

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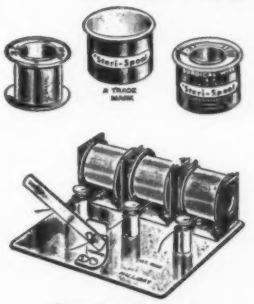

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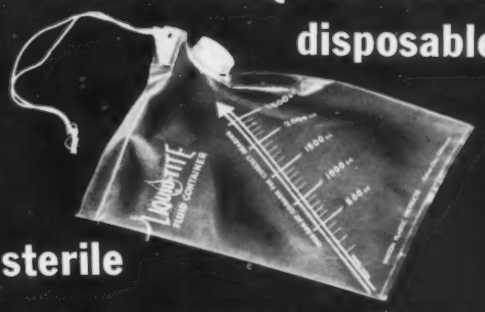

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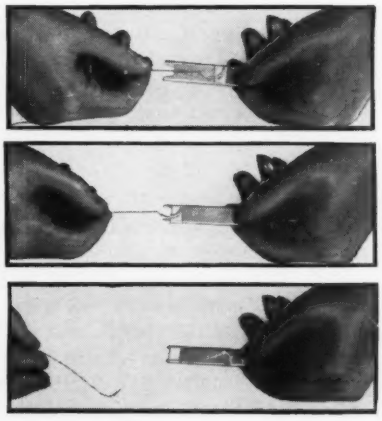

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Patient Care Study

Patients and Personnel Speak: A Method of Studying Patient Care in Hospitals. By Faye G. Abdellah, R.N., Ed. D., and Eugene Levine, M.P.A. Washington, D.C.; Public Health Service Publication No. 527. 1957. 33 pp. 30 cents.

At last, a practical, how-to-do-it manual spells out every detail of how to discover what patients and personnel really think and say about hospital service.

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In turn, the checklists were tested by a series of pilot applications to ensure their validity in representing significant areas of omission or commission in terms of service expectations of patients and patient-care personnel. Finally methods were developed and tested to demonstrate how to implement the study and how to measure the relative importance of each factor of dissatisfaction.

The manual details step-by-step procedures leading to distribution and completion of checklists by patients, personnel with patient contact at the bedside, and medical staff. Tabulating, evaluating and interpreting responses is made easy by use of the simple mathematical formula included. Specimen worksheets for each stage of the study are presented in prototype.

Patients and Personnel Speak was developed as a joint venture of the PHS division of nursing resources and the American Hospital Association. It presents a sound and proved method for uncovering and measuring, in relative terms, weak spots at the most sensitive point in hospital-patient relationships. It has equal applicability to large or small hospitals.

Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., this manual is a tailor-made opinion survey that can be put to use easily and effectively.—*Carl I. Flath*, associate consultant, John G. Steinle and Associates, Garden City, N.Y.

Outline Planning to Meet Mental Health Needs

A plan of community action to meet the mental health needs of its citizens is outlined in "Your Community and Mental Health," a 25-cent pamphlet available from the Public Affairs Committee, 22 E. 38th St., New York, N. Y.

The pamphlet summarizes ideas presented at the 1957 National Health Forum. It contains guides to discovering a community's needs, discusses obstacles and how to overcome them, and outlines factors in developing successful community mental health programs.

Physical Therapy Manual

Physical Therapy: Essentials of a Hospital Department. Joint Committee of the American Hospital Association and the American Physical Therapy Association. Chicago: American Hospital Association. 1957. $1.50.

This manual is not a revision but a replacement of the 1949 edition, providing both a different approach to the subject and more comprehensive subject matter. It assists the hospital administrator in assessing the justification for a physical therapy department and provides guide lines for the appropriate establishment and maintenance of this service once it has been justified.

(Continued on next page)

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A section on personnel in the manual includes: (1) suggestions for dealing with the problem of medical direction; (2) qualifications, activities, and responsibilities of the physical therapist; (3) duties for nonprofessional assistants; and (4) suggested personnel requirements for departments with various case loads.

Equipment Guide Given

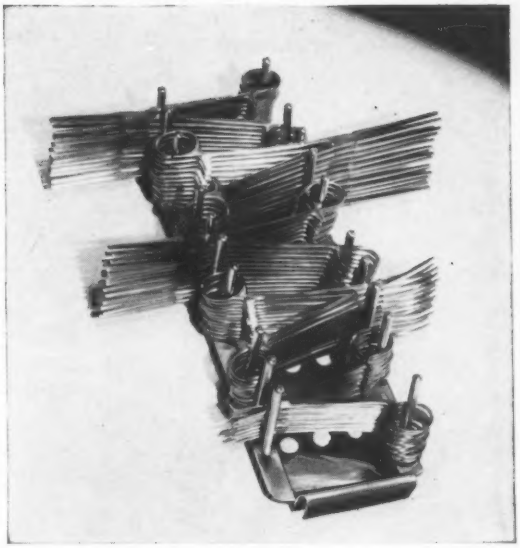
The importance of space, location, and work areas has been outlined from the functional standpoint and references to ventilation, sinks, interior finishes, doors, and ceiling moorings are included. The supplementary material contains detailed scale diagrams of effective arrangements of work components as well as of placement of equipment within the individual units. Guides have been provided for the following: (1) selection of equipment in relation to number of professional staff members; (2) space requirements for specific equipment; and (3) suggested daily linen supply.

Other valuable contributions will be found in the sections on finance and budget, litigation, equipment and installation safeguards, staff work habits, and housekeeping, and in the special references to pertinent publications.

This manual merits consideration by anyone proposing to set up a department or center, and it could well be reviewed to advantage by those responsible for existing physical therapy services. — *June M. Schroeder, R.P.T.*, chief physical therapist, University of Illinois Research and Educational Hospitals, Chicago.

The New KIDD Instrument Rack

Every O. R. Supervisor Has Been Waiting For!



Holds 60 to 75 artery forceps—conveniently sorted by type and size. Permits handy removal of instruments—one or several—without disturbing the others.

Simplifies sorting and storing—before and after sterilization. Fosters proper sterilizing technique by holding forceps with jaws open. Perforated tray bottom ensures thorough steam or gas penetration.

A SIMPLE AND TIME-SAVING TECHNIQUE

Sort and rack forceps as they are cleaned, slipping rings over the uprights to prevent unintentional falling out and to hold instruments open for thorough sterilization . . . Wrap and autoclave loaded rack . . . Store as sterile pack until needed . . . Carry loaded rack to instrument table for use . . . Note rack prevents forceps from touching table surface.

Saves Space, Too! Holds maximum number of forceps in a minimum of space for rapid convenient selection during surgery.

Sturdy, single unit construction—nothing to assemble or disassemble—tough stainless steel for daily heavy duty.

Overall length is less than 15½ inches—fits 16" chamber. **Each, $17.50**

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- Effectively sterilizes practically *all* instruments, dressings or sundries—including those which can't be subjected to usual methods.
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SD-1200 BEN VENUE Sterilizer, With 12 Steribulbs.....$85.00
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Armamentarium

List Suggested Tips for Writing Congressmen

One of the most powerful weapons Americans have for influencing legislation in Congress is writing to their state representatives in Washington. Members of professional associations are frequently urged to express their opinions to their congressmen concerning pending legislation which might have far-reaching effects for them.

The following suggested steps for writing congressmen are designed as an aid to making most effective use of this privilege. These steps are reprinted, with permission, from the April, 1958, issue of the American College of Radiology's *Monthly News Letter*.

- **Write on a specific issue or principle and don't try to cover more than one in a letter.**
- **Be brief. Tell your point of view and your reasons.**
- **Don't follow a form letter. Give your own ideas in your own way. It is the straightforward, sincere letter that commands attention.**
- **Emphasize how the issue involved affects you, your family, your practice, your community, your industry, and the public interest.**
- **Be friendly and courteous. Don't be abusive.**
- **Don't use carbon copies. Write to each one individually.**
- **Write a "thank you" note when your representative does something you like. They are often criticized, seldom praised.**
- **Be sure to sign your letter legibly and give your address.**

Florida Hospital Cited By Management Institute

Baptist Hospital, Pensacola, Fla., recently won an "excellently managed" rating from the American Institute of Management, in the first audit of a hospital to be made by that organization.

Opened in 1951, the hospital "has had to cope with more than 100 percent expansion without endowment funds or major fund-raising drives," the institute stated.

It praised the hospital for its planning for community medical care and for holding per diem costs, per admission costs, and operating costs per patient below both national averages and comparable Florida and South Atlantic area averages. The hospital has operated at a surplus from its first year.

"This financial record was not gained at the expense of patients, but is due to good management," the institute found. Pat N. Groner is administrator of Baptist.

The institute applied a 10-category system of study to the hospital, similar to its comparative studies of industry, emphasizing that all types of management must apply similar principles although using differing technics.

AMA Names Associate Head Of Hospitals Council

John C. Nunemaker, M.D., has been appointed associate secretary, American Medical Association Council on Medical Education and Hospitals. He had been director of education service, VA Department of Medicine and Surgery, since 1952.

The VA has also announced the following personnel changes:

Edward Dunner, M.D., has been appointed chief, clinical studies division, VA Department of Medicine and Surgery. He had been secretary of the VA-Armed Forces co-operative study on the chemotherapy of tuberculosis, and chief of VA tuberculosis research.

James W. Raleigh, M.D., former chief, tuberculosis service, VA Hospital, Sunmount, N.Y., will succeed Dr. Dunner as secretary of the VA-Armed Forces study.

Ivan F. Bennett has resigned as chief of VA psychiatric research to become head of clinical research in psychiatry for Eli Lilly and Co. His successor in the VA position has not been named.

Diamond Edges keep scissors sharp for years!

New OCHSNER Diamond edge scissors have tungsten-carbide edges, (hardest metal known to man) laminated to tough Swedish surgical steel.

Razor edge sharpness is maintained up to 100 times longer than conventional surgical-type scissors.

Easy to recognize, ring handles are gold plated for quick and easy identification.

Available in the following sizes:

METZENBAUM	Light dissecting scissors	5¾" curved	**$15.30**
	Light dissecting scissors	5¾" straight	**$15.30**
	Dissecting scissors	7" curved	**$15.30**
	General dissecting scissors	9" curved	**$26.25**
MAYO	Dissecting scissors	5½" straight	**$14.25**
	Dissecting scissors	5½" curved	**$15.30**
	Dissecting scissors	6¾" straight	**$14.50**
	Dissecting scissors	6¾" curved	**$15.50**
GENERAL	Dissecting scissors-Mayo points	9" curved	**$25.75**
	Dissecting scissors-Mayo points	9" straight	**$24.75**

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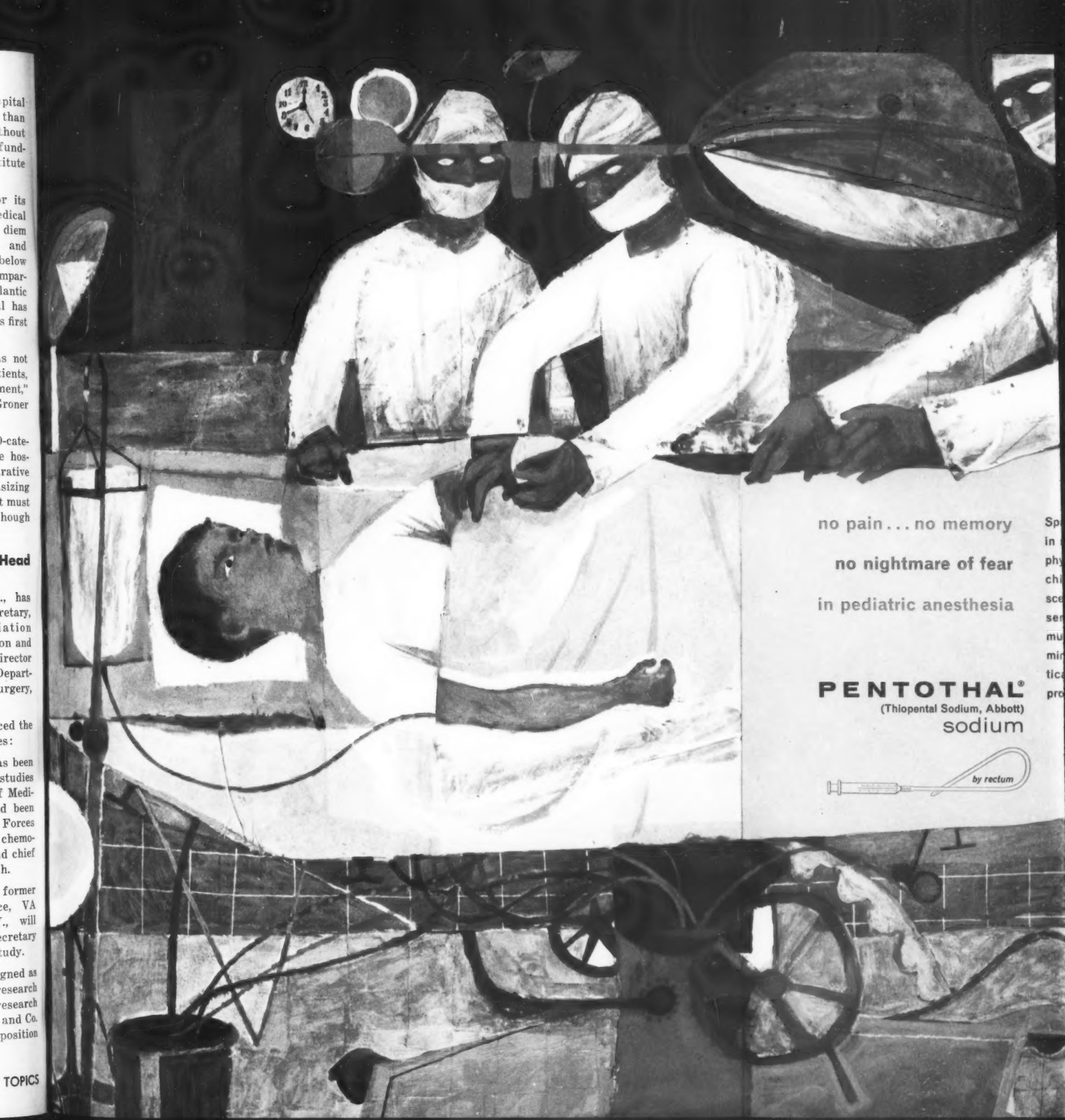
no pain . . . no memory
no nightmare of fear
in pediatric anesthesia
PENTOTHAL®
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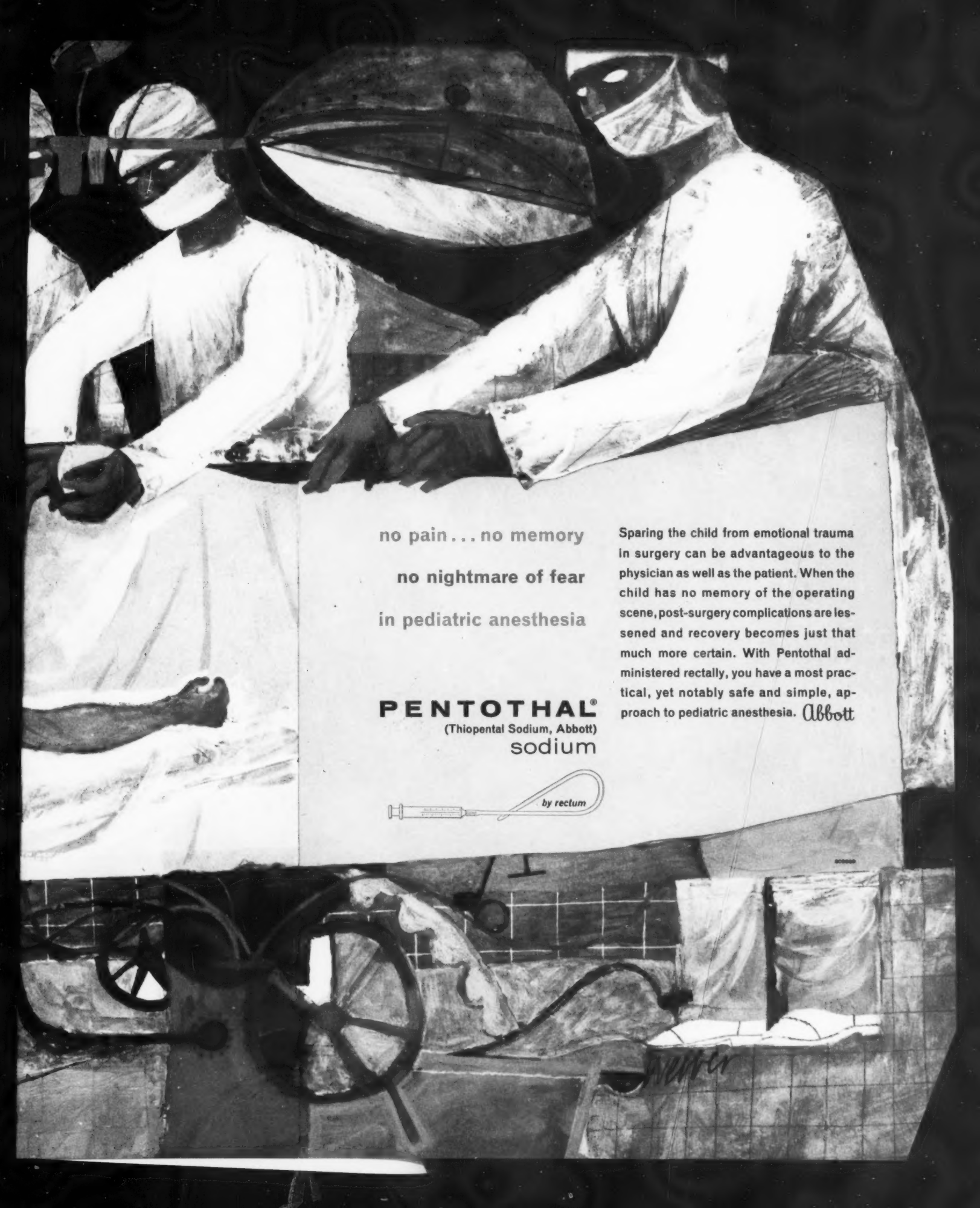
sodium
by rectum


no pain . . . no memory
no nightmare of fear
in pediatric anesthesia
PENTOTHAL®
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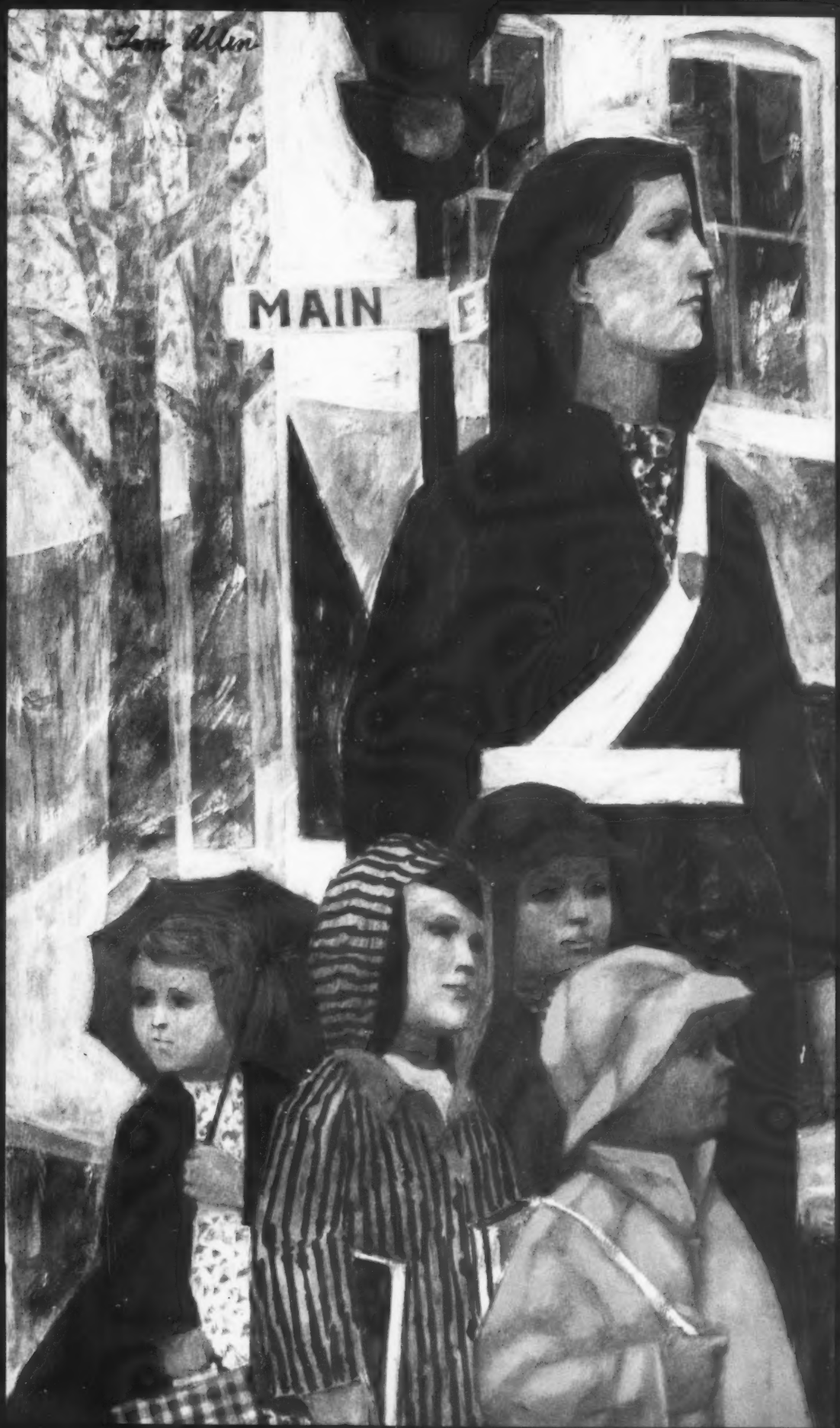
sodium
by rectum
Sparing the child from emotional trauma in surgery can be advantageous to the physician as well as the patient. When the child has no memory of the operating scene, post-surgery complications are lessened and recovery becomes just that much more certain. With Pentothal administered rectally, you have a most practical, yet notably safe and simple, approach to pediatric anesthesia. Abbott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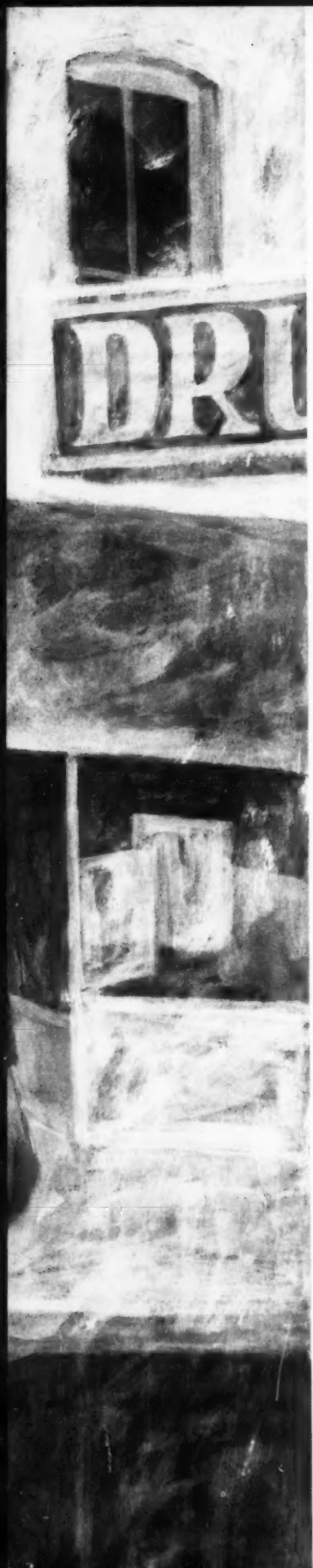

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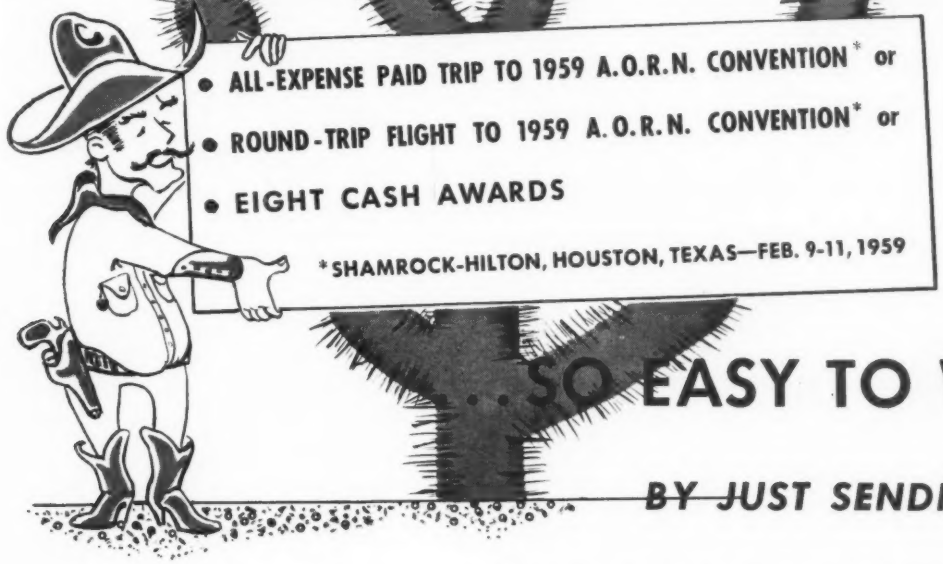

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1. Only actively-employed Operating Room Supervisors and Operating Room Nurses are eligible for Austenal Appreciation Awards.

2. All entries will be judged on *originality* and *practicability* of suggestions or ideas concerning the use, handling, storing or packaging of Vitallium Surgical Appliances and Instruments. The best suggestions, in the opinion of the judges, win.

3. All entries should be legible and include: name, home address, phone number, and hospital where employed, on each page submitted.

4. Address entries to: Surgical Division, Austenal, Inc., 224 E. 39th St., New York, N.Y. All entries must be postmarked prior to midnight, November 15, 1958.

5. All entries will be judged by the Awards Panel. They are: Miss Pauline Young, R.N., President, AORN, ORS, Hahnemann Hospital, Philadelphia; Miss Edith Dee Hall, R.N., Exec. Secretary, AORN; Miss Hazel Evans, R.N., ORS, Hospital For Special Surgery, New York; Miss Ruth Schmidt, R.N., ORS, Presbyterian Hospital, Chicago; J. H. Begert, Austenal, Inc.

6. The awards are: *First*—All-expense paid trip to 1959 AORN Convention, Houston, Texas; *Second*—Round trip flight to 1959 AORN Convention; *Third*—Cash award of $100.00; *Fourth, Fifth*—Cash awards of $75.00 each; *Sixth* thru *Tenth*—Cash awards of $50.00 each. All winners will be notified by December 15, 1958.

7. All entries become the property of Austenal, Inc. and the decision of the judges is final.

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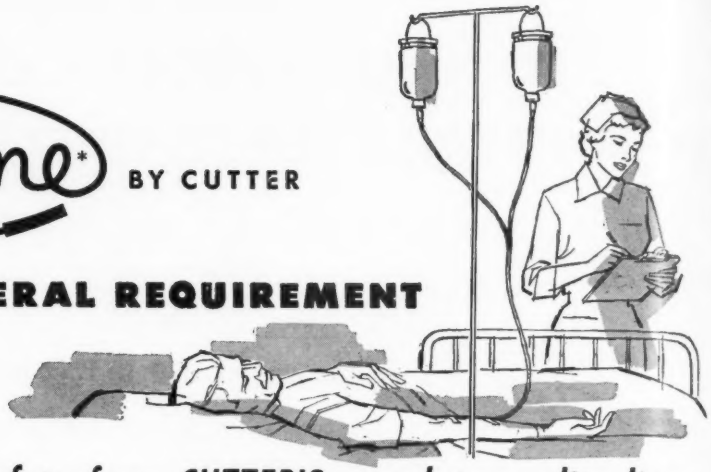

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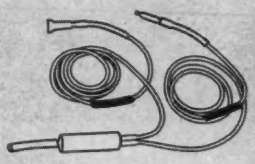
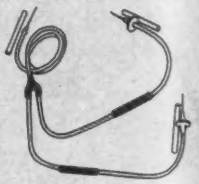
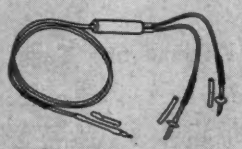
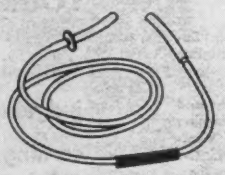
Saftiset "Streamliner"* I.V. Infusion Set	 **Safticlysis*** Hypodermoclysis Injection Set	**Saftifilter "Y"*** Blood and Plasma Y-Tube Set	 **Saftidonor "Y"*** Blood Donor Y-Tube Set
 **Saftiset "Y"*** I.V. Infusion Y-Tube Set	**Saftifilter*** Blood and Plasma Infusion Set	 **Saftidonor*** Blood Donor Set	**Pediatric Scalp Vein Infusion Set**

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HOSPITAL Topics OR

Official bulletin for the
Association of Operating Room Nurses

Planning for 1959 AORN Scientific Program

MEMBERS of the local committees for the sixth national congress of the Association of Operating Room Nurses met with Edith Dee Hall, R.N., executive secretary, in a series of conferences when Miss Hall visited Houston in September to complete plans for the 1959 congress.

Shown above in one of several meetings concerning the program and scientific exhibits are (seated, l. to r.): Agnes Dornak, R.N., St. Luke's - Texas Children's Hospital, program; Rose Pizzitola, R.N., St. Luke's-Texas Children's Hospital, scientific exhibits; Miss Hall; Edna Ashy, R.N., assistant O.R. supervisor, VA Hospital, general chairman; Mrs. Marie B. Ellison, R.N., O.R.S., St. Luke's-Texas Children's Hospital, program chairman; Oneta Williams, R.N., head nurse, operating room, St. Luke's-Texas Children's Hospital, scientific exhibits chairman; and Elizabeth Saunders, R.N., assistant director of nursing service in charge of the operating room, University of Texas Medical Branch Hospitals, Galveston, scientific exhibits committee.

Standing: Imogene Creber (l.), R.N., O.R.S., M. D. Anderson Hospital, chairman, promotion committee; and Midge Duncan, assistant O.R. supervisor, M. D. Anderson Hospital, scientific exhibits committee.

For the latest news on speakers and topics for the congress, please turn the page.

Closed-Circuit TV to Be Feature of Houston Meeting

Program topics include:

- **Pitfalls in Planning New O.R. Departments**
- **Hand Scrubs and Skin Preparation**
- **Open-Heart Surgery**
- **Hospital Infections**

• For the first time, closed-circuit television will be presented at an AORN congress. Members of the local planning committee for the Houston congress, February 9-12, 1959, have announced that there will be at least one and perhaps two color telecasts from the M. D. Anderson Hospital to the Shamrock-Hilton Hotel.

Plans are nearly completed for the scientific program, according to Edith Dee Hall, R.N., executive secretary, and Edna Ashy, R.N., general chairman of all local committees for the congress.

Speakers and topics already confirmed are:

Alton Ochsner, M.D., professor of surgery, Tulane University School of Medicine, New Orleans, "Carcinoma of the Lung."

Michael E. DeBakey, M.D., professor of surgery, Baylor University College of Medicine, Houston, "Thoracic and Abdominal Aneurysms."

Louis J. Girard, M.D., clinical assistant professor of ophthalmology, Baylor University College of Medicine, Houston, "New Trends in Intraocular Surgery."

Ellard M. Yow, M.D., professor of medicine, Baylor University College of Medicine, Houston, "Today's Problem of Infections."

Philip B. Price, M.D., dean, University of Utah School of Medicine, Salt Lake City, "Hand Scrubs and Skin Preparation."

Fred Guilford, M.D., clinical assistant professor of otolaryngology, Baylor University College of Medicine, Houston, "Restoration of Hearing by Surgical Technics."

Helen Creighton, R.N., J.D., assistant professor, Georgetown University, Washington, D.C., "Malpractice Suits and Insurance for O.R. Nurses."

A panel presentation on radiation protection will be given by the staff of the M. D. Anderson Hospital and Tumor Institute, Houston. It will include the following:

"Principles of Radiation Protection"—Warren Sinclair, Ph.D., head of physics department.

"Operating-Room Procedures in Radiotherapy"—Lowell Miller, M.D., assistant radiotherapist.

"Nursing Responsibility for Radiation Protection and Patient Care"—Renilda Hilkemeyer, R.N., director of nursing.

"The Role of Operating-Room Nursing Personnel"—Imogene Creber, R.N., operating-room supervisor.

As a part of this program, there will be a color telecast from the hospital's operating room, through the co-operation of R. Lee Clark, Jr., M.D., director.

Another panel discussion, on "Roadblocks to the Supply of O.R. Professional Nurses," will have the following participants:

Charles Allen, M.D., chief anesthesiologist, University of Texas Medical Branch Hospitals, Galveston; Sister Mary Giles, R.N., O.R.S., St. Mary's Hospital. Kansas City, Mo.; Mary Roberts, R.N., O.R.S., VA Hospital, Dallas; Faye Pannel, R.N., dean, school of nursing, Texas Women's University, Parkland Memorial Hospital, Dallas; and a surgeon whose name will be announced in the near future.

Subjects of other discussions include "Pitfalls in the Planning of New O.R. Departments" and "Recovery and Postanesthesia Units." There will also be a discussion of O.R. teaching programs for graduate nurses, professional student nurses, and technical aides. Speakers on these topics will be announced next month.

On the fourth day of the meeting, following the formal lecture program, tentative plans call for presentation of a color telecast of open-heart surgery from the M. D. Anderson Hospital.

The advance program for the congress will appear in the November issue of HOSPITAL TOPICS, along with information on scientific exhibits, descriptions of products to be displayed in technical exhibits, and details on plans for the fourth day's program.

Greetings to All Members:

It's good to be back from vacation and into the swing of a busy fall. I hope all of you had an enjoyable vacation, too, and that you are now ready to give your untiring effort to our goal: the best possible patient care in the operating room.

I hope, too, that you will have enough reserve energy left to help develop the democratic mechanism of the AORN. It is your association. Let us have your suggestions and comments on how it can best meet the needs of all members.

An excellent program has been lined up for the Houston congress, February 9-12. Plan now to attend. And during the meeting, I hope it will be my privilege to meet many of you.

Sincerely,
PAULINE R. YOUNG, R.N., President
Association of Operating Room Nurses

Additional Companies Plan AORN Congress Exhibits

Several more companies have announced plans to exhibit their products at the sixth national AORN congress in Houston. The following names have been added to the list of exhibitors published in the August issue of HOSPITAL TOPICS:

Barnes-Hind Ophthalmic Products, Inc.; the Bircher Corp.; Eaton Laboratories; Hollywood Turban Products Co.; J. A. Majors Co.; Massillon Rubber Co.; T. J. Noonan Co.; Orthopedic Equipment Co.; Phelan Mfg. Co.; and Roehr Products.

Inadvertently omitted from the list in the August issue were the Bard-Parker Co., which has exhibited at every AORN congress, and the Wilson Rubber Co. Both companies are divisions of Becton, Dickinson and Co., and will occupy booths adjoining that company's display.

Sacramento AORN Names New Officers

New officers of the Sacramento (Calif.) Association of Operating Room Nurses are shown below. Standing: Amanda Bouillon, R.N., (l.), Sacramento County Hospital, treasurer; Grace Nolan, R.N., Sutter General Hospital, secretary. Seated: Elsie Wiedmann, R.N., Sacramento County Hospital, president; and Thelma Sheets, R.N., Mercy Hospital, vice-president.

O.R. Procedure Manual For Open-Heart Surgery

By Audrey N. Bell, R.N.*

Introduction

• The first open-heart procedure at Parkland Memorial Hospital was performed in November, 1956. In January, 1957, when routines were becoming more established, we began writing this manual. The bound manual was printed in October, 1957, and 200 copies were available for distribution. These copies have been sent to many medical centers in the United States, Mexico, Germany, and South America.

We offer this manual only as a guide in developing a procedure in other hospitals, because we know that no two hospitals can operate using identical procedures. However, we do hope that the manual will answer many questions and in some way spare other operating-room nurses a few of the headaches which are always present when new operating-room procedures are being developed to assist the surgeon in his ever-expanding field of surgery.

This procedure was developed for Parkland Memorial Hospital in conjunction with the Southwestern Medical School of the University of Texas, under the auspices of Hugh E. Wilson, M.D., assistant professor of surgery, cardiothoracic division.

Part I. Preparation of Supplies and Equipment

Tubing for Heart-lung Oxygenator

Technician — Pump Team:

Cut tygon tubing to proper lengths. Graduate Helix and mark with wood-burning electric pencil; color markings with black Magic-Marking pencil. Wash tubing thoroughly with blood and tissue detergent; rinse well with final rinsing in distilled water. Deliver tubing to operating room and separate pieces for various packages. Tubing should be delivered at least two days previous to surgery.

Nurses:

Package and autoclave tubing. Roll Helix tubing onto the 13″ diameter drum, cover with 10″ stockinette, and place safety pins at scattered intervals to hold tubing apart. Wrap in large table covers. Fold the last cover so that a handle is made on two sides for lifting the hot tubing. The drum is covered with a muslin wrapper and stockinette before being used. The stockinette cover is replaced as it becomes discolored.

Place the oxygenator tubing on a muslin-covered plywood board, 30″x6″. Hold tubing in place by covering with two towels and pinning at the long edge of the board with safety pins. Do not pin so tightly as to compress the tubing, but pin snugly so that tubing is held straight. Wrap in two large muslin wrappers.

Coil the nurses' tubing loosely on an 18″ square plywood board which has been covered with a muslin wrapper. Wrap in two large muslin wrappers.

Place the pump team connecting tubing by layers in a large instrument basin with a towel between every two layers of tubing. Wrap in two large muslin wrappers.

The above packages are sealed with autoclave indicator tape and labeled "Helix," "Oxygenator," "Nurses' Tubing," and "Pump Team Tubing," respectively.

Autoclave the packages of tubing in the steam sterilizer at 250° F. for 30 minutes, with sterilizer set for "fast exhaust and dry." Transfer the packages to the hot-air oven and dry for two hours at 215° F. Do not overexpose at higher temperatures, because the tubing will discolor or melt.

Connectors

Technician — Pump Team:

Assort, clean, and deliver the proper connectors, bellows, nylon filters, and metal clamps to the operating room.

Nurses:

Package all connectors except ones with sharp edges in a small basin with the bellows, nylon filter, and metal clamps. Place nylon filters on glass rod or culture tubes to maintain shape. Wrap basin in two muslin wrappers and autoclave in steam sterilizer at 250° F. for 30 minutes, with sterilizer set on "fast exhaust and dry." Do not dry in hot-air oven.

Place sharp-edged connectors in basin of Zephiran 1:1000 for 18 hours to sterilize.

*Miss Bell is operating-room supervisor, Parkland Memorial Hospital, Dallas, Tex.

Polyethylene Bottle and Defoamer

Technician — Pump Team:

Cut and wash polyethylene bottle and deliver to the operating room.

Nurses:

Fill instrument washer with distilled water and boil polyethylene bottle for 30 minutes to sterilize on morning of surgery. The bottle cannot be autoclaved, because it will melt in the sterilizer.

Four #756 Kurley-Kate stainless steel sponges are used as the defoamer. The sponges must be carefully washed to remove loose metal deposits. Pull each sponge apart to loosen the strands, and place in the instrument washer with blood and tissue detergent. Wash for 15 minutes at 270° F., 27 pounds pressure. Wrap and autoclave the sponges for 30 minutes at 250° F. or place unwrapped in high-speed sterilizer for five minutes at 270° F. on morning of surgery.

Cannulae

Surgeon:

Cut the plastic catheters to the proper lengths and cut the holes in the tip of each for the cannulæ. Select sizes to be used for the case.

Nurses:

Provide the surgeon with plastic catheters, sizes 8-26 French, and 3/16″ I.D. plastic tubing from which he cuts the arterial and caval cannulæ.

Flange the ends of the cannulæ. They can be flanged easily by heating in boiling water and placing on connectors until cool. Place a silver wire stylette in each cannula and place in basin of Zephiran chloride 1:1000 for 18 hours to sterilize.

Potassium Citrate 20%

Technician — Pump Team:

Prepare the potassium citrate solution in 30-cc. rubber-stoppered vials. Label and pull a 10-cc. vacuum in the vial. Deliver to the operating room for sterilizing.[1]

Nurses:

Autoclave the vials in the steam sterilizer for 20 minutes at 250° F., with sterilizer set for "slow exhaust." Date bottles as to date of sterilization and use. Store partially-used bottles in the refrigerator.

Ivalon Sponges

Surgeon:

Select the desired thickness of cut Ivalon; place in press plates and compress to required thickness. Prepare two press plates of Ivalon.

The press plates are made of two heavy, polished pieces of stainless steel, 6″ square. The bottom plate has a threaded pin, 1″ high, on each corner. The top plate has a hole in each corner through which the threaded pins fit. The Ivalon sponge is placed on the bottom plate; the top plate is then placed in position and held in place by wing nuts on the pins. The top plate is pressed down until the Ivalon has been compressed to the desired thickness.

Nurses:

Wash the uncut Ivalon sponges according to the manufacturer's instruction to remove the formalin and glycerine. Let them dry to their natural state.

Cut sponge on the meat slicer (in main kitchen) to ½″, ⅜″, and ¼″ widths. One sponge is cut lengthwise and another cut widthwise. Wash the cut sponges again, dry, and store in plastic bags until needed.

Before the cut sponge is pressed, rinse in distilled water, because the sponge must be wet when placed in the press plate. Store the press plates of compressed sponges in distilled water until autoclaved.

To sterilize, place press plates containing Ivalon sponge in square basin with bottom plate down. Cover with distilled water, and place in steam sterilizer for 45 minutes at 250° F. with sterilizer set on "fast exhaust." Transfer to room by transferring basin to a cart draped with a sterile sheet; cover. *Caution:* Do not touch edges of basin when removing plates.

If unpressed Ivalon is needed, the piece is autoclaved with the press plates. It is not necessary to cover the unpressed Ivalon with distilled water, but merely to place it in the water.

Water Bath

Nurses:

Move water bath into the saline room the afternoon before surgery and fill with distilled water to just above the overflow valve. Turn on LOW heat setting. Cover the unit with a Mayo tray and leave on all night, so that temperature will remain constant. Check occasionally to see that temperature is being maintained. Temperature must stay between 37°-40° C.

Pressure Equipment

Metabolic Team:

Prepare and sterilize pressure tubing and connectors and deliver to the operating room. If blood samples are to be taken during surgery, bring sterile, specially prepared syringes to the operating room the morning of surgery.

Nurses:

Check with the metabolic team regarding the tubing, connectors, and syringes. It may be necessary to sterilize the tubing in surgery. If so, place in a basin of Zephiran chloride 1:1000 for 18 hours.

Suctions

Technician — Pump Team:

Cut and deliver tygon tubing for intracardiac suction to the operating room with the oxygenator tubing.

Nurses:

Package and sterilize intracardiac suction tubing with the "nurses' tubing."

Prepare two calibrated suction bottles and two sets new suction tubing. Sterilize two plastic suction tips in basin of Zephiran chloride 1:1000.

(*Continued on next page*)

[1]American Cyanamid Co., Lederle Division, is now preparing these vials for us. They are not a regular item, however.

The plastic suction tips must have four holes drilled in the end. They are made with the dental drill using a #6 burr.

Intracardiac reservoir: Sterilize in 30" s/s catheter basin in Zephiran chloride 1:1000.

Instruments

Surgeon:

Notify nurse of age and weight of patient; also of any special instrument which might be needed.

Nurses:

Select, package, and autoclave instruments; check with surgeon for any special instruments.

Linen

Nurses:

Check to see that the following packs are prepared and sterilized:

Pump team pack
Gown pack—heart surgery
Drape pack—heart surgery
Syringe and basin pack
Suture kit.

Place three cotton blankets and two small sandbags or small pillows in room for positioning.

Miscellaneous Equipment

The following teams are responsible for placing or delivering the following equipment to the operating room:

Pump Team:

Pump complete with handles, and oxygenator complete with tubing.

Metabolic Team:

pH meter and pressure recording machine.

Blood Bank:

Heparinized and citrated blood.

Anesthesia Team:

Anesthesia machine and table
Hypo-hyper thermal unit, complete
E.K.G. machine
Oximeter
Defibrillator and electrodes
Pacemaker
Rectal thermometer.

Nurses:

Miscellaneous equipment (see Part II, next month) PLUS:

2 auxiliary spotlights
4 large instrument tables
4 small instrument tables
3 infusion standards
3 blood culture sets
Scale for weighing patient
(Bed scale from artificial kidney room for adults; Detecto scale for children)
Special Pacemaker electrode and indifferent plate, sterilized*
Extra supply of cardiac drugs
All trays of sterile supplies
3 sets blood culture tubes (from bacteriology).

*Pacemaker electrodes:

1. Pericardium: Cover atraumatic stainless steel wire suture with polyethylene tubing; seal end by heating; sterilize in Zephiran chloride solution.
2. Indifferent plate: Cut a 1¼" x ⅜" tantalum plate, leaving small handle on one end; bend handle to right angle and cover with rubber sleeve; sterilize by autoclaving.
3. Equip Pacemaker cord with alligator clip-type jaws for quick use.

The second part of the manual, which lists equipment and supplies for open-heart surgery, will appear in the November issue.

New Edition of NFPA Bulletin 56 Available

Several important changes have been made in the latest edition of "Recommended Safe Practice for Hospital Operating Rooms" (NFPA No. 56), published by the National Fire Protection Association.

One of the most important changes is the statement that recirculation of air in anesthetizing locations does not increase the hazards of fire and explosions from flammable anesthetic vapors.

The committee explains in the booklet: "Available data and recent investigations indicate that under customary operating procedures, flammable anesthetic mixtures are diluted by air in the anesthetizing area to a nonflammable range before reaching a vertical height of one foot from any source of leakage or spillage involving quantities of anesthetics used in anesthesia procedures."

Another significant change makes it mandatory for relative humidity in anesthetizing locations to be maintained at not less than 50 percent.

The revised recommendations allow fixed lights installed in the ceiling to be supplied from a conventional grounded circuit, "provided the wiring for the secondary of the ungrounded system shall be kept entirely independent of all other wiring and equipment, and shall not enter the same raceway, box, or cabinet with other wiring except in case of transfer switches of emergency lighting systems."

If the switches of the conventional grounded circuit serving these fixed lights are installed within the anesthetizing location, they will be required to be of explosion-proof design and manufacture.

There are other revisions in requirements dealing with electrical wiring and equipment. In addition, there are revised suggestions for the testing and maintenance of conductive flooring, furniture, and equipment.

This edition of the pamphlet supersedes all previous editions (the last one was in 1956). Copies of the 52-page bulletin may be obtained from the National Fire Protection Association, 60 Batterymarch St., Boston 10, Mass. They are 25 cents each.

Carolyn Fisher, recently named operating room supervisor, Wills Eye Hospital, Philadelphia, receives the NBC Public Service Award from Curtis Peck, (l.) director of operations at NBC stations in Philadelphia. The award cited Miss Fisher for her work in prevention and care of blindness and in the instruction of eye patients. Observing the presentation is Melvin Sutley, superintendent of the hospital. Miss Fisher has been associated with Wills Hospital since her graduation from Community General Hospital, Reading, Pa., in 1952.

AORN President Named To NFPA Committee

Pauline R. Young, R.N., Philadelphia, national president, Association of Operating Room Nurses, has been appointed to the Committee on Hospital Operating Rooms of the National Fire Protection Association. The appointment, made by the American Hospital Association, is for one year, and is effective through the 1959 meeting of the group.

Miss Young

The committee includes representatives of more than 20 organizations concerned with operating-room standards.

The only other nurse member is Harriet L. Aberg, R.N., of the American Association of Nurse Anesthetists.

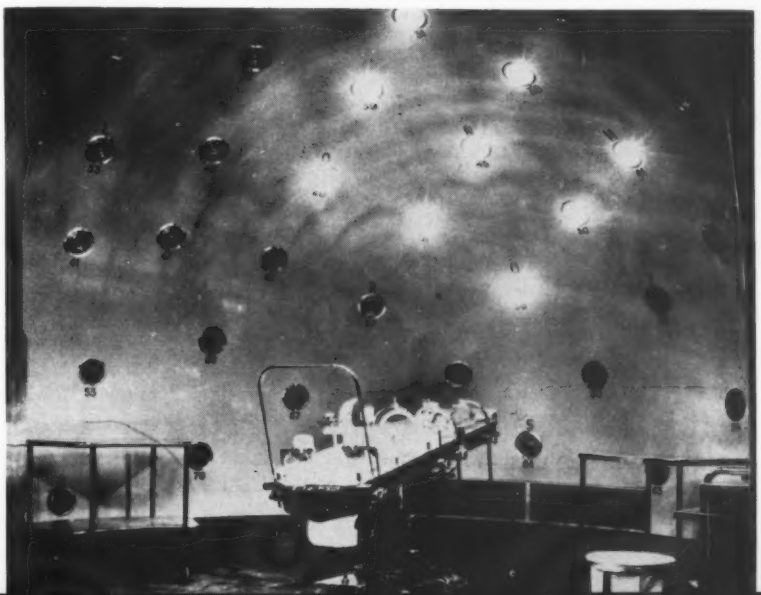
A longtime member of the committee is Carl W. Walter, M.D., associate clinical professor of surgery, Harvard Medical School, Boston, who represents the American College of Surgeons.

• The "egg-shaped" operating room below is one of six in an ultra-modern hospital opened early in September in Copenhagen, Denmark.

"All relevant factors have been integrated into a controlled form," said architect Paul Nelson, now a member of the New York firm Ketchum and Sharp, Paul Nelson, Associated Architects. "As a result, the egg-shaped room is more than a space; it has become an instrument."

Features include 71 lighting projectors arranged within the walls to give surgeons a multiplicity of lighting possibilities.

The unusual design was decided upon by a committee of Danish medical specialists who investigated new hospitals throughout Europe for the most advanced developments in operating-room design. There are 12 other egg-shaped operating rooms in France, Belgium, and Canada, according to Mr. Nelson, who created the room in a project done for the Suez Canal Surgical Pavilion in 1935.



New Surgery Technics Discussed at AMA

• *The following abstracts are of selected papers presented before the recent annual convention of the American Medical Association in San Francisco.*

Heart Surface Procedures Create New Blood Transport Network

Three hundred forty-seven patients have been operated upon in the last four years with the Beck operation, which consists of several procedures carried out on the surface of the heart, to create a new network which will send blood to muscle formerly supplied by an artery blocked off by heart disease.

For the entire group, which included 110 patients with severe artery and muscle damage, the hospital mortality was six percent and the subsequent mortality was nine percent. But for 234 more favorable cases the hospital mortality was three percent and the subsequent mortality, seven percent.

Patients are gotten out of bed on the first day after operation and are discharged from the hospital in two weeks.

In a recent survey of results, 94 percent received an excellent or good result. The pain was either cured or greatly diminished, and the patients were able to return to their former jobs or to light work.

The operation should be performed prophylactically on members of families in which the disease is known to exist. The risk of such early operation would be almost negligible, compared to the risk of the disease later on when it is too late to operate. —*Claude S. Beck, M.D., David S. Leighninger, M.D., Bernard L. Brofman, M.D.,* and *Jess F. Bond, M.D.,* Western Reserve University School of Medicine, the University Hospitals, and Mount Sinai Hospital, Cleveland.

Treat Coronary Insufficiency With Mammary Artery Implant

To evaluate six surgical methods currently used in the treatment of human coronary artery insufficiency, we created coronary artery constriction in experimental animals, using a method which causes the death of all control animals within an average of 30 days.

The mortality rate from ameroid coronary constriction in 40 animals thus studied was 90 percent, practically the same as the rate in the control animals. The internal mammary artery implantation procedure is the only one which consistently protects the animal's life when both the anterior descending and circumflex coronary arteries are narrowed by ameroid constrictors.

To speed up the development of intercoronary anastomoses, the coronary sinus is partially ligated at the time of internal mammary artery implantation. This permits the implanted internal mammary artery to send systemic blood throughout the left ventricle within six weeks instead of six months.

Our experimental evidence shows the urgent need for revascularization in patients in whom the coronary artery narrowing is causing anginal pain.

One hundred seven cases of coronary heart disease have been treated by internal mammary artery implantation. The operative mortality for 83 patients with no angina at rest was 3.6 percent. Seventy-six percent of these patients were unable to work, and few could walk more than one block. Seventy-six of this group have been followed from six months to eight years, with a loss of only 13 percent, making a combined operative-late mortality of 17 percent.

Fifty-eight patients, or 76 percent of the original group, returned to work after operation. Forty-four, or 59 percent, had no pain or slight pain.

In contrast to this group, there were 24 patients with angina at rest. These patients came too late. There was little or no heart muscle left to revascularize.

Fourteen human internal mammary arteries have been examined after implantation. Eleven, or 79 percent, were found patent. Four of these had been implanted from 18 months to three years previously. —*Arthur Vineberg, M.D.,* Montreal, Que., Canada, and *James Walker, M.D.,* Charleston, W. Va.

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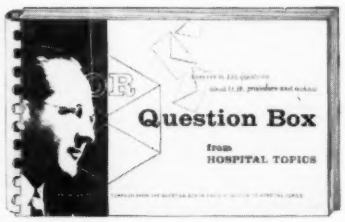

O.R. QUESTION BOX
By Carl W. Walter, M.D.
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Authoritative answers to 195 questions most frequently asked on operating room procedure and technic, compiled from the author's regular column in HOSPITAL TOPICS. This book will be a valuable reference aid to operating room supervisors and staff, directors of nurses, medical staff members, central supply supervisors, and administrators who want to keep informed on good operating room practices.

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SELECTED BIBLIOGRAPHY

By Dorothy W. Errera, R.N.

Suggestions will be welcomed for subjects to be covered in future issues.—The Editors.

LoGrippo, G. A., Burgess, B., Teodoro, R., and Fleming, J. L.: "Procedure for Bone Sterilization with Beta-Propiolactone." *J. Bone and Joint Surg.* 39-A:1356, Dec., 1957.

The experimental methods used for removing pathogenic organisms from animal tissues are described, and a simple, rapid, inexpensive method for applying these technics to the preservation of human material is presented. The technic is practical for small hospitals and has yielded specimens which have been used with excellent results in 50 operations. Precautions to be observed in the use of beta-propiolactone are outlined in detail.

Editorial: "American Reaction to the Staphylococcus." *Lancet* 1:1055, May 17, 1958.

Agreeing fully with the current recommendation in this country that a committee on infections be appointed in every hospital, this editorial suggests one further refinement: The appointment of a hospital infection officer, who should be a professionally mature person of consultant stature.

This person would have the freedom of action and the responsibility necessary to effect changes which are essential to control the spread of infection in an institution. He would have the freedom to investigate any and all ramifications, would be fed reports and findings from his committee, and would communicate his own findings freely to the entire hospital staff.

It is believed that concentration of information, responsibility, and action in such a person is necessary to ". . . control the increasing scandal of hospital cross-infection—a scandal which we seem unable to prevent by the gentle processes of self education and self discipline."

Editorial: "The Tourniquet." *Lancet* 1:1161, May 31, 1958.

"The most important thing about putting on a tourniquet is to take it off." With this provocative warning, the editorial outlines a routine for safe use of a tourniquet.

One member of the surgical team should have full and continuous responsibility for management of the tourniquet, and a written record of time of application and release should be kept. The safe period of compression varies with patient age, environment, body temperature, and limb damage; this time has been reported to range from four to six hours. However, the editorial suggests that the tourniquet when used in elective surgery, should be released after an hour. This time should be extended to a maximum of 2 hours only under extreme circumstances.

Below-the-knee tourniquets have no place in surgery. A pneumatic cuff should be used on the upper limb; use of an Esmarch bandage should be restricted to the thigh. In any event, tourniquets are applied over toweling to avoid direct pressure on the skin.

Indications for the use of tourniquets are outlined and the distinct contraindication to use in aged patients and those with peripheral vascular disease is clearly stated.

Khalil, H. H.: "Hypothermia by Internal Cooling in Man." *Lancet* 1:1093, May 24, 1958.

Discussed is a system for body cooling which is believed to have advantages over surface cooling or extracorporeal blood cooling.

In brief, the system cools by providing a continuous flow of cold or warm water through an intragastric balloon. The tube is introduced in the anesthetized patient and the balloon filled with 1.5 liters of water from a tank. The patient is placed in a semi-sitting position, and a pump and cooling compressor drop the temperature of the circulating water to 5° C. (41° F.). As the water in the stomach warms, it is automatically replaced with cold water from the tank by a system which prevents overfilling of the stomach.

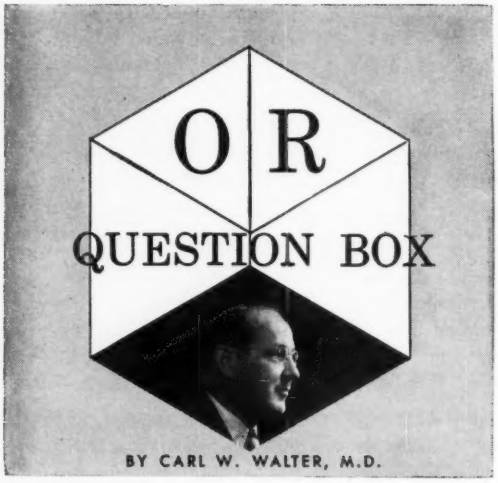
By controlling the temperature of the circulating water in the tank, the patient's body temperature can be raised or lowered as the moment of surgery dictates. In one case reported, the patient's temperature dropped from 36.8° C. (97° F.) to 32.2° C. (90° F.) in 75 minutes; and to 26° C. (78.8° F.) in four hours.

Gershenfeld, Louis: "Povidone-Iodine as a Topical Antiseptic." *Am. J. Surg.* 94:938, December, 1957.

A chemically stable combination of iodine and polyvinylpyrrolidone was tested on bacteria obtained from pathologic processes: *Micrococcus pyrogenes* var. *aureus; Salmonella typhosa; Streptococcus hemolyticus;* and *Pseudomonas aeruginosa.*

Aqueous solutions containing 1 percent free iodine, in dilution up to and including 1:10, killed on contact and within 15 seconds all the bacteria in a 4-mm. loop. These results were consistent with and without the presence of blood (10 percent) or blood serum (5 percent).

The combination is reported to be a more stable solution of active iodine because vapor pressure of the iodine is reduced. It is reported to be seldom irritating to skin or mucous membranes and to be without the disadvantage of staining. Residual color left on the skin after use is removable with water.



Assisted by Dorothy W. Errera, R.N.

Q. Do you think nail files might be a source of cross-contamination between personnel? We have a diamond nail file attached to a chain over each scrub sink. We also have containers of orangewood sticks. Is it necessary to autoclave nail files and orangewood sticks each time after use? Would you recommend discontinuing the use of a nail file in favor of orangewood sticks? At what point in the scrubbing procedure do you recommend cleaning the nails?

A. Stainless steel nail files should be sterilized and provided at the scrub sink so that each individual can use a sterile one. Orangewood sticks are completely useless devices because they are too soft and often leave slivers imbedded in subungual tissues. The subungual spaces should be scraped out with a sharp-edged stainless steel nail file sometime during the course of the scrub. It is preferable to do this beyond the midway point rather than at the onset, to prevent implanting bacteria in the skin.

Q. We are concerned about the proper procedure for postoperative urinary drainage with both retention catheters and supra-pubic catheters. At present we are using rubber tubing and also plastic tubing. This tubing is sterile. A rubber stopper, sterile, is inserted into a non-sterile glass jug. Is it necessary to have the rubber stopper sterile? Is it possible for bacteria to grow up the tube?

A. Sterilization of drainage equipment at intervals of 3 or 4 days is essential to control the growth of urea-splitting organisms in urine. This simple precaution is an excellent way to avoid the development of odor in wards where patients with genitourinary complaints are cared for. Disposable transparent plastic drainage tubing is used widely because incrustation does not occur and cleanliness is easier to attain. Plastic bags for the collection of urine eliminate the hazard of broken glass and are lighter and more comfortable for the ambulatory patient to manage.

Retrograde siphonage of urine in ambulatory patients is a bacteriologic hazard that is often forgotten. This is an obvious reason for utilizing sterile drainage equipment. A continuing flow of urine cannot be depended upon to prevent bacteria from gaining access to the bladder by growing upward through a column of stagnant urine. Remember that a bacterial generation is but 20 minutes.

Q. When open reductions are done, the x-ray machine is brought up from the x-ray department. Would it be a good idea either to wipe the machine with alcohol or to wash it with soap?

A. The machine can be wet-dusted with a detergent-germicide mixture. Particular attention should be given the wheels and casters before the machine is wheeled into the operating room.

Illustrated Manual Outlines Specific Surgical Procedures

Operating Room Technic. St. Mary's Hospital. Fifth Edition. Philadelphia: W. B. Saunders Co. 1957. 346 pages. $7.50.

The preface to *Operating Room Technic* is probably its best review: ". . . to give the surgical nurse an outline of specific procedures supplemented with illustrations to contribute to her understanding of the work of the surgeon." Using excellent illustrations and terse, explicit directives, the Sisters of Saint Francis guide the operating-room nurse through the maze of Surgery—1957.

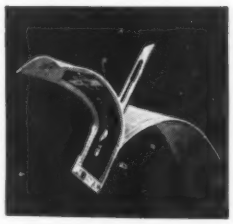
In this text, as in many others, usefulness is diluted by geography. The standard tools of the giants of surgery have lost their identification in the welter of personal modifications, but this text is kinder than most in that it provides adequate illustration, allowing the harassed operating-room nurse of the East to orient her "Smith-Jones-Brown-White" clamp to its identical twin of the "Abel-Cain-Adam" West.

There is a minimum of local vernacular in the text, but one cannot avoid mention of "salts," a term which appears throughout the book, provoking the imagination of the reader. While this homely vernacular may bring smiles of reminiscence to the vast army of Mayo-St. Mary's-St. Teresa graduates, perhaps the uninitiated should know, at least by page 10, that this is an 8-ply, 12 × 12 gauze square!

The Sisters have nicely reduced to a sensible working minimum the jumble of operating-room inventory once considered essential for even the most superficial surgical encounter. Also, they have candidly eliminated any discussion of asepsis or management, preferring to leave such considerations to the concentrated texts available in the field.

It is true that this text represents the surgical philosophy and technics of the Mayo Clinic surgical staff. However, as such, it is a determinative guide for organizing similar treatises suitable for use in a local situation.—*Dorothy W. Errera, R.N.*

What every O.R. Nurse should know about A·S·R STERISHARP blades



Q. *What is a SteriSharp?*

A. It is a sterile-packed surgical blade made from a special alloy of extremely hard stainless steel. Like all stainless-steel surgical instruments it will not rust or corrode in hospital use.

Q. *Aren't all sterile-packed blades made from stainless steel?*

A. No, only SteriSharps. All others are made from ordinary carbon steel which rusts, corrodes and dulls quickly when autoclaved or kept in solution.

Q. *Are SteriSharp blades sharper than carbon steel blades?*

A. Yes. SteriSharps' imported high-chrome alloy Swedish steel is hardened, tempered, ground and sharpened under processes developed by A·S·R to give it a sharper, longer lasting cutting edge.

Q. *Can I autoclave the sealed SteriSharp packet?*

A. Yes. Neither autoclaving nor dry-heat sterilizing harms the packet or the blade inside. This means you can include any number of SteriSharp packets on the instrument tray. The sterile nurse can then open blades as needed. And all unopened packets can be returned to stock.

Q. *Can I autoclave SteriSharp blades out of the packet?*

A. Yes. Unlike carbon steel blades which blacken, rust and lose their edge when autoclaved, SteriSharp blades can be autoclaved repeatedly without damage. Thus, SteriSharps which have been opened but not used can be returned to stock. This eliminates blade waste. SteriSharps can be stored indefinitely without harm.

Q. *How does A·S·R make sure that SteriSharps are 100% sterile?*

A. SteriSharps are ultrasonically cleaned before packaging. The packets are sealed securely and are heat-sterilized at a time-and-temperature cycle well above highest hospital requirements. Each lot is sampled *twice*, and blades are tested for sterility by A·S·R's own bacteriologists according to USP XV (revised). Each lot is also checked by an independent laboratory.

Q. *How can I be sure SteriSharps come to me 100% sterile?*

A. Test them in your own laboratory. We will be happy to send you a detailed description of our sterility testing methods.

Q. *Can SteriSharps be re-used?*

A. After their work in the Operating Room, SteriSharps can be autoclaved and distributed to Pathology and other blade-using departments.

Q. *How do SteriSharps compare in cost with other sterile-packed blades?*

A. SteriSharps cost less.

Q. *How do SteriSharps compare in cost with ordinary carbon steel blades?*

A. SteriSharps do away with jars and solutions and eliminate blade waste. In addition, the greater durability of stainless steel means longer blade life. Surgeons report that during procedures where extensive cutting is required, one SteriSharp does the work of as many as six ordinary carbon steel blades. Hospitals using SteriSharps report dollar savings of 25% and more over conventional nonsterile carbon blades.

Q. *Do SteriSharps come in all standard sizes and fit all standard handles?*

A. Yes. In addition, when you contract for SteriSharps, you will receive FREE as many stainless-steel dispensers as you need for your O.R. suite and other blade-using departments.

Q. *How can I find out more about SteriSharps?*

A. Write: A·S·R HOSPITAL DIVISION, DEPT. HT, 380 MADISON AVENUE, NEW YORK 17, N. Y.

In Canada—A·S·R HOSPITAL DIVISION, 2055 DESJARDINS AVENUE, MONTREAL, CANADA

Literature and samples for your evaluation available upon request. If you have further questions—ask us.

A·S·R precision products

SteriSharps . . . the first and only sterile, stainless-steel surgical blade

• The "problem clinic," a popular session at every national AORN congress, was divided at the 1958 congress into two meetings—one for small hospitals (15 to 75 beds) and one for average and large hospitals. Questions from both these panel discussions have been selected to appear in this column. This month's questions were taken from the session for average and large hospitals.

PANEL: *Dean Theresa I. Lynch,* School of Nursing, University of Pennsylvania Hospital, Philadelphia, moderator.

L. Kraeer Ferguson, M.D., professor of surgery, Woman's Medical College of Pennsylvania and University of Pennsylvania Graduate School of Medicine.

Charles S. Paxson, Jr., administrator, Hahnemann Medical College and Hospital, Philadelphia.

Edward T. Lawless, M.D., anesthesiologist, St. Joseph's Hospital, Paterson, N. J.

Dorothy L. Hufcut, R.N., chief, nursing service, VA Hospital, Wilmington, Del.

Mary Jane Venger, R.N., director of nursing, Albert Einstein Medical Center, Philadelphia.

Sister Mary Albina, O.R.S., St. Agnes Hospital, Philadelphia.

Mrs. Doris Deimel, O.R.S., Rockaway Beach (N.Y.) Hospital.

Mrs. Lillian Sholtis Brunner, R.N., consultant in medical and surgical nursing, Bryn Mawr (Pa.) Hospital School of Nursing.

Q. Should an operating-room supervisor have the opportunity to select new equipment? Should she have a definite say in what type or brand she prefers?

MR. PAXSON: It isn't a question of the brand she *likes,* but of the brand or piece of equipment which will be most valuable in the particular situation. I think she should be consulted. This or other equipment may have been used in the past. If the chief of surgery, the anesthesiologist, and the administrator feel her judgment is sound, they will take her suggestion.

The operating-room supervisor, the physician who is going to use the equipment, the engineering department which will maintain and repair it, the purchasing department—all should have something to do with the selection of a new piece of equipment. The brand frequently is simply a matter of pricing.

Q. Why are administrators so reluctant about asking the advice of the operating-room supervisor when they are developing a new O.R. suite?

MR. PAXSON: I can't imagine designing an operating-room unit without the consultation of the nursing service—the director and the O.R. supervisor, and the whole team, along with the physicians.

SISTER M. ALBINA: I believe the supervisor is consulted on big things, such as a table, a surgical light, or an autoclave.

But when a salesman comes around with a good buy, the purchasing agent may buy something that we can't use—a simple thing like a mask. The strings of the mask are too short. The first surgeon puts the first one on, and down on the floor it goes! There may be a hundred masks floating around in the operating room or the dressing rooms. At noontime we're out of masks, and we wonder why.

I think that when such items are purchased, the purchasing agent should be sure to see the sample and try it on.

DR. LAWLESS: I don't think cost is a consideration in every case. Cost is perhaps the only one the purchasing agent really thinks about. But when it comes to purchasing instruments which are the personal choice of a surgeon, I don't believe a purchasing agent should be willing or able to say: "We won't get that, we'll get one made by Smith and Co., that costs half as much," because the surgeon probably knows about the one made by Smith and Co., and doesn't like it.

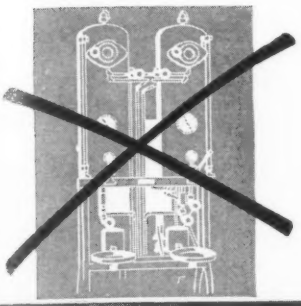
The same thing is true of sutures. Every once in a while we find ourselves using sutures that we didn't know we ever had. And we find out that the reason is that the purchasing agent decided that these were cheaper. Price is not the only consideration. It seems to me that before any purchase is made the persons who use these things on patients should be consulted.

Q. Shouldn't the policy-making committee make these decisions or recommendations, Dr. Ferguson?

DR. FERGUSON: Yes. But when it comes to individual instruments, I don't know how the policy-making committee can really function.

DEAN LYNCH: The operating-room committee generally meets once a month unless a special meeting is called. Before that

(Continued on page 124)



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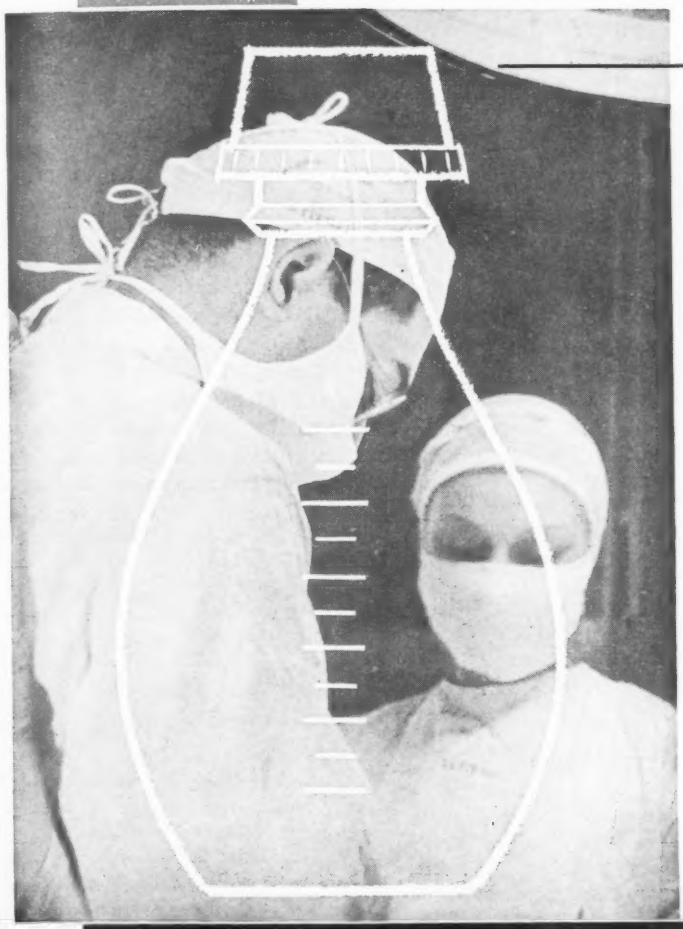

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PROBLEM CLINIC

(Continued from page 122)

month is up there are many, many things the supervisor needs—instruments, suture material, a lot of expendable items—and nobody knows what to buy except the people using these things.

I think it should be seriously considered that the operating-room supervisor's recommendations go through.

MR. PAXSON: The example of the masks points up the problem of specification buying. Most purchasing departments, I'm sorry to say, have not developed adequate specification buying and bidding. A standard towel clamp which might have so many serrated teeth and be of standard description can be a bid item. But an individual instrument, maybe specially made for the surgeon, is an item which cannot be bid. It's a matter of defining these items.

I think that the operating-room committee can establish standards for sutures and many other items —and that the purchasing agent should not vary from those standards without specific prior authorization.

MISS VENGER: It seems to me that there should be some planning in preparation for a fiscal year's work on the basis of experience and suggestions from the people involved. Perhaps such planning would eliminate some crisis buying.

SISTER M. ALBINA: In teaching institutions, and I mean medical schools, there is so much progress from day to day, from month to month, that in the specialty fields it is rather difficult to try to anticipate what the next year's budget is going to be. For routine work it is a simple matter.

Q. Dr. Ferguson, how would you go about reducing the number of instruments in general use in the operating room? There are certainly many very similar instruments. How can you get surgeons together on a standard in the usual instruments?

DR. FERGUSON: I don't believe that would be too difficult if an effort were made to do it. Most surgeons use the instruments that they learned to use as they grew up. Their chief used those instruments, and so they use them. If an effort were made to standardize, I believe that standardization could be achieved.

DR. LAWLESS: I believe it is a function of the surgical operating-room committee or surgical liaison committee to decide what type of suture material should be used, select the majority of instruments to be used, in consultation with the various department chiefs, and distribute the list to the members of the staff.

MRS. BRUNNER: Certainly any teaching in the operating room is greatly facilitated when as much as possible is standardized.

Q. Is there a trend toward having patients in a waiting room before they go to the operating room, or should they go directly to the operating room?

DR. LAWLESS: It's impossible with our busy operating rooms today to have a patient come directly to surgery and into an operating room. There usually is a waiting period. Ideally there should be some sort of waiting room or staging area for patients coming to surgery. In the average busy hospital, though, that staging area is in the corridor right outside the operating room where a lot of busy traffic is usually taking place.

The staging area could be a pre-anesthesia room or a somewhat larger room—just an area in which patients could be left by themselves, quiet, and would not be exposed to the traffic and the busy schedule of an operating-room corridor.

Q. As a surgeon, Dr. Ferguson, how do you feel about that?

DR. FERGUSON: I agree that it is very bad for patients to be in the corridor, where they often see, through open doors, other operations going on, and where they see patients being taken to and from the operating room.

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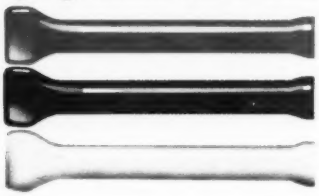

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55458

Set-Up Trays Designed for Efficiency, Eye Appeal, Handling Ease

• When Mrs. Margaret Lee, R.N., supervisor, central supply department, Mount Sinai Hospital, Los Angeles, was unable to find a tray for procedure set-ups with the specifications she needed, she designed a new one herself.

She had found that the shape of available trays did not fit well in the new, 8-story building which Mount Sinai moved into three years ago. Average shelves were 12 or 15 inches deep and dumb waiters were sized proportionately. To accommodate the greatest number of trays in the least amount of space, a new size was needed.

In addition, Mrs. Lee wanted a tray which would be quieter to handle, lighter in weight, and more colorful. Today, the trays she designed to meet these needs are manufactured to her specifications by General Plastics Co., Los Angeles, and are used for more than 40 types of set-ups.

The trays are made in two sizes—5½ inches by 11 inches, and 11 inches by 12 inches. The material used is Royalite, a plastic with the texture and consistency of hard rubber, which provides a firm working base and is lightweight, washable, and quiet to handle. The color is a warm blue-gray which blends with the cheerful tones used throughout the hospital. However, red trays are used for contaminated syringes and needles, thermometers and holders.

TRAY CONTENTS SIMPLIFIED

The contents of the trays underwent some redesigning also. An effort was made to simplify the set-ups so that only needed items would be included. The tray contents for each of the more than 40 set-ups were approved by physicians and departments, after which they became standard for that procedure.

Stock set-ups range from routine prep trays to equipment for bedside surgical, medical, and diagnostic procedures, such as preparations for tracheotomy or thoracentesis. One thoracentesis tray is incorporated in a spontaneous hemothorax set-up and is kept ready for emergency use at all times. A "cardiac cart," containing equipment and drugs for treatment of cardiac emergencies, is also kept in the department ready for use.

One of the standard tray set-ups is a patient admitting kit. Equipment includes a disposable urine bottle, oral thermometer, tissues, soap, and body lotion.

Factors of quietness, efficiency, and color appeal entered into the selection of items for the trays, also. Mrs. Lee introduced the use of polyethylene squeeze bottles for solutions such as alcohol and antiseptics. In addition to being quieter than glass or metal, they enable practice of a better technic.

Disposable items are used whereever possible. A disposable needle pilot program is now under way at the hospital. Ultrasonically precleaned disposable needles are attached to reusable glass syringes. Each needle is covered with a piece of Koroseal plastic tubing to assure maximum sharpness. The units are autoclaved in stainless steel boats, which are covered and issued to each floor.

(*Continued on next page*)

Two of the standard set-ups are enema tray, which utilizes the 11- by 12-inch plastic tray, and patient admitting kit, prepared in smaller of the two tray sizes. Enema tray carries disposable tubing; patient kit's urine bottle is also disposable. Patient tray also contains cellulose tissues, prewrapped, patient-size bar of soap, body lotion.

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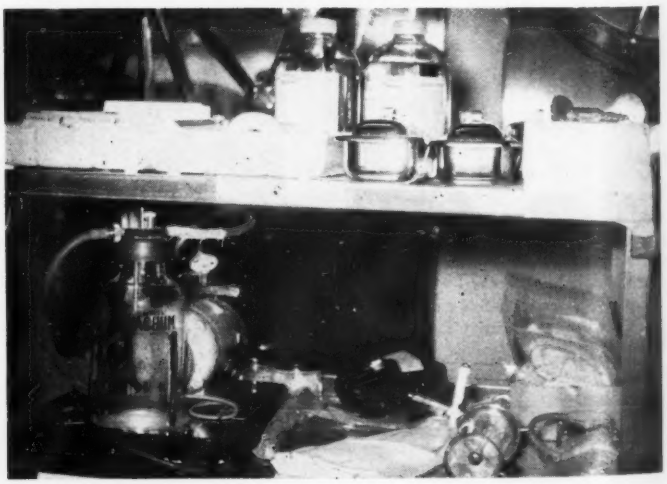
Maxine Newman, R.N., assistant central supply supervisor, lifts dressing tray from storage shelf in department's sending area. Dumb waiter which carries fresh trays and clean items to nurses' stations on each floor is in this area.

Close-up of dressing tray shows polyethylene squeeze bottles used for solutions. Sterile instruments are put in covered metal container. Tray set-up includes culture tube, brown paper bag for waste materials. Sterile gloves and towel are paper-wrapped.

Cardiac cart is kept ready at all times with standard drugs and equipment for emergency treatment of cardiac patients. Equipment also includes laryngoscope, blood pressure apparatus, disposable oxygen mask. Readings from oxygen recorder are taken by central supply personnel daily.



Mrs. Margaret Lee, R.N., supervisor of the department, demonstrates holder she devised for clean, used needles ready to be reassembled with syringes. Holder is made by covering cardboard box with sponge rubber, then bright green cloth. To guard against their nicking or dulling, reusable needles are prevented from touching metal at any time during cleaning, assembling, and storage.

CENTRAL SUPPLY continued

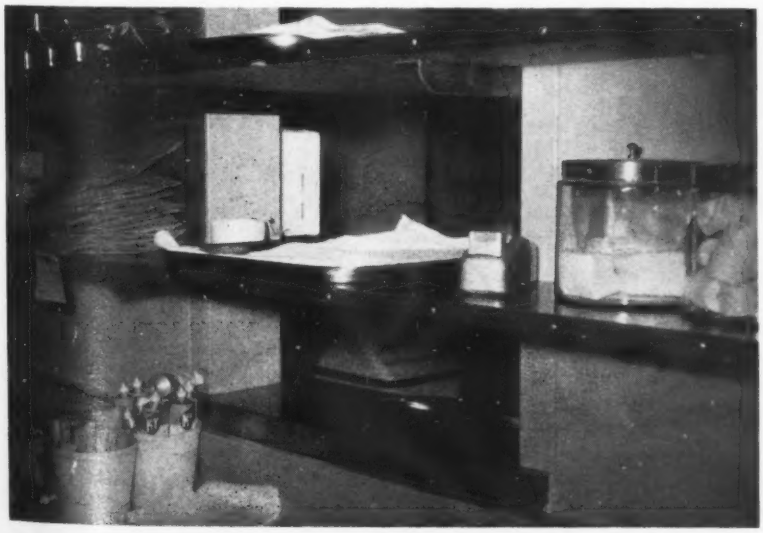
The program is designed as a step toward better patient care by providing maximum comfort as well as safety in administration of injections. Reusable syringe and needle combinations are also used. When these are handled in the department, special precautions are taken to insure that the sharpness of the needles is not marred by contact with metal.

Items to be autoclaved are wrapped in paper. Carrying out the planned eye-appeal of color, the paper used is blue, in a 25-pound Kraft stock. In tests at Mount Sinai and other hospitals in the area, the paper has proved satisfactory if some care is exercised, and, as Mrs. Lee points out, "it is less noisy than parchment."

Occasionally aluminum foil is used for wrapping also. In a technic devised by Maxine Newman, R.N.,

(*Continued on next page*)

Picture taken from assembly area of department looks into utility room. In background is dumb waiter which collects dirty items from floor utility rooms and returns them to central supply where they are cleaned, then passed over counter to assembly table.



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assistant supervisor of the department, Vaseline gauze is wrapped loosely in two thicknesses of foil, then autoclaved. After sterilization, the folds of the foil are tightened, and the packets stored.

Only three linen items are handled by the department. These include a spinal sheet, towels for draping, and a towel for providing a sterile field, and are used for such bedside procedures as a spinal tap. Such set-ups employ a stainless steel tray. Towels and other items for the procedure are placed on the tray which is then wrapped in paper and packaged together with the sheet before autoclaving.

Surgical packs, muslin-wrapped, are made up by operating-room personnel in the surgical workroom across the hall from the central supply department. The packs are then brought to central supply for autoclaving after which they are sent to the surgery department, housed on the same floor.

In a separate section of the surgical workroom, gloves are washed in home-type automatic machines, run at a minimum, 4-minute cycle. After being tested and powdered in this section, the gloves are brought to central supply for packaging and sterilization.

Except for operating-room instruments, everything sterilized in the 170-bed hospital, including patient utensils and equipment, is autoclaved in the central supply department. In addition, the department does autoclaving of supplies for the hospital's research staff which is quartered on the top floor of the building.

WORK FLOW BY AREAS

Work flow in the department is arranged by area. Two dumb waiters connect central supply with the floors. One, located in the department's sending area, opens at the nurses' stations and is used to send clean items and trays to the floors. Stock tray set-ups are sent to the floors daily and replenished twice during the day. Other trays are sent on request.

The second dumb waiter opens at the utility rooms on the floors. On it, dirty items and used trays are sent down to the central supply utility room. There, the items are washed as they are taken from the dumb waiter; after cleaning, items are passed on to the assembly area where the trays are made up and other assembly work carried out.

In this area is a Kardex file with a separate card listing the approved, standard set-up for each procedure. As the worker makes up the tray, she checks the items on the card and, when finished, places her name on the tray.

The autoclave area is situated between the assembly area and the work-table section. In the latter area, all items are marked and then either sent to the operating room or put in the department's sending area.

The smooth flow of work in the busy department attests to the ingenuity of the over-all planning of the section just as the plastic trays illustrate the careful attention to detail.

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PERSONALLY SPEAKING

(Continued from page 57)

Sister Jane Frances—formerly office manager, has been named administrator, Sudbury (Ont., Canada) General Hospital of the Immaculate Heart of Mary. She replaces **Sister M. Patricia,** who has been transferred to Port Arthur, Ont.

Sister Josephine — has been appointed administrator, St. Vincent's Hospital of St. Louis. She was formerly assistant administrator, St. Vincent's Hospital, Los Angeles.

Sister M. Theophane — has been promoted to administrator, St. John's Hospital, Cleveland, O. She had been treasurer since 1955.

Sister Theophane succeeds **Sister M. Mercia,** who had served as administrator since 1952.

Sister Madeline Maria—has been appointed administrator, Queen of the World Hospital, Kansas City, Mo., succeeding **Sister Mary Mercy, M.D.,** who has been elected vicaress general of the Maryknoll Sisters.

Sister Mary de Paul and **Lorraine A. Harrington** — have been appointed assistant administrators, St. Mary's Hospital, San Francisco. Sister Mary was previously director of nursing at the hospital.

Sister Mary Grace—is the new administrative resident, St. Francis Hospital, Hartford, Conn. She has been studying at St. Louis University.

Sister Mary Pauline—is being transferred from Sacred Heart Hospital, Lamar, Colo., at which she was superior and superintendent, to Great Bend, Kans.

Sister Rose of the Precious Blood —is the new administrator, Lewis Memorial Maternity Hospital, Chicago. She succeeds **Sister Marguerite de Montmarte,** who will be assigned to the mother house of the Sisters of Charity of Providence, Montreal, Que., Canada.

Sister Rose formerly served at St. Elizabeth Hospital, Yakima, Wash.

Grace L. Stumpf—director of dietetics, Ohio State University Hospital, Columbus, has been appointed dietetic consultant for the Air Force Medical Service. She is also assistant professor in the university's School of Home Economics.

Helen M. Tucker—has been appointed administrator, Bel-Aire General Hospital, Miami, Fla.

James Watson—formerly administrator, Suffolk Sanatorium, Holtsville, Long Island, N.Y., has been appointed director, public relations and fund raising, Caledonian Hospital, Brooklyn, N.Y.

Helen Wilks—has been named dietitian, Marion County General Hospital, Columbia, Miss.

Earnil D. Zornes, Jr. — has been appointed business manager, East Coast Hospital Association, St. Augustine, Fla. He was formerly on the administrative staff of Marshal College, Huntington, W. Va.

VA Appointments

Alexander W. Kruger, M.D.—manager, Brooklyn, N.Y., VA Hospital, has been named administrator, Muskogee (Okla.) VA Hospital.

Mildred C. Meyere—has retired as chief dietitian, VA Hospital, Columbia, S.C.

VA Nursing Appointments

M. Elizabeth Kuehn—has been named assistant chief, nursing education, VA Hospital, Fort Harrison, Mont., where she was formerly acting assistant chief.

Mary Panigal—is assistant chief, nursing education, VA Hospital, Clarksburg, W. Va. Prior to transfer she was an instructor at the Cleveland, O., VA Hospital.

Eleanor Rutan—is assistant chief, nursing education, Oklahoma City VA Hospital. She held a similar position at the Pittsburgh, Pa., VA Hospital prior to transfer.

Rose Schamine—has been named assistant chief, nursing service, Buffalo, N.Y., VA Hospital, where she was formerly acting assistant chief.

Virginia Shively — is assistant chief, nursing education, Coatesville, Pa., VA Hospital. She was formerly a supervisor at the North Little Rock, Ark., VA Hospital.

Frances Sumner—formerly an instructor at the Waco, Tex., VA Hospital, is now assistant chief, nursing service, at the hospital.

(Continued on next page)

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OPERATING ROOM SUPERVISOR. 350-bed general hospital, active surgical service. Clinical experience and special preparation in operating room supervision. B.S. desired. Liberal personnel policies, salary open. Apply director, Nursing Service and School of Nursing, St. Luke's Hospital, New Bedford, Mass.

New Officers

James E. Case, administrator, Tuomey Hospital, Sumter, S.C., has been named president-elect of the South Carolina Hospital Association. **Esther Touchberry, R.N.,** superintendent, Marion Sims Memorial Hospital, Lancaster, S.C., was elected to fill Mr. Case's unexpired term on the association's board of trustees.

* * *

Foster L. Fowler, executive director, Mississippi Commission on Hospital Care, was installed as president, American Association of Hospital Planning, during the group's annual meeting, held in Chicago in August.

* * *

Clyde L. Reynolds, executive director, Provident Hospital, Chicago, was elected president of Alpha Delta Mu, national professional hospital administration fraternity, at the group's annual meeting in August.

Other officers elected were: **John E. Milton,** administrator, Edward Hospital, Naperville, Ill., first vice-president; **Wayne E. Henry,** assistant director, Newton-Wellesley Hospital, Newton Lower Falls, Mass., second vice-president; **Kenneth C. Etcheson,** Halesity, N.Y., third vice-president; **Mary Ann Gilster,** purchasing agent, West Suburban Hospital, Oak Park, Ill., secretary; and **Harold E. Springer,** administrator, Memorial Community Hospital, Edgerton, Wis., treasurer.

* * *

Vernon Stutzman, executive director, Methodist Hospital of Brooklyn, N.Y., has been named president, Hospital Council of Brooklyn, Long Island, and Staten Island.

* * *

Chester M. Warman — controller, Methodist Hospital of Indiana, Indianapolis, has been chosen secretary, Indianapolis Control, Controllers Institute of America.

Named as a director of the Institute's Twin Cities Control is **Richard T. Crist,** vice-president and controller, Minnesota Hospital Service Association, St. Paul.

Donald F. Walker, treasurer, the Liebel-Flarsheim Co., has been elected vice-president, Cincinnati Control.

* * *

Katharine W. Wright, M.D., Chicago, has been elected president, American Medical Women's Association. First vice-president is **Margaret J. Schneider, M.D.,** Cincinnati, O.

Deaths

Francis V. Britt—53, administrative assistant for buildings and grounds, Presbyterian Hospital in the city of New York, died recently. He had been at the hospital since 1955.

Mr. Britt had served in the Civil Engineering Corps, U.S. Navy, and had also worked in the engineering departments of Western Union and the Birds Eye Division, General Foods Corp.

Jesse W. Cofty—42, administrator, Cookeville (Tenn.) General Hospital, died June 13. Mr. Cofty was formerly administrator, Jackson Hospital, Marianna, Fla.

Warren F. Cook, Ph.D.—73, former regent, American College of Hospital Administrators, died August 21. He had served as executive director, New England Deaconess Hospital, Boston, from 1929 to 1954.

Dr. Cook was a past president of the Massachusetts Hospital Association and the New England Hospital Assembly.

George David Cutler, M.D.—73, died August 2. He had been associated with Milton Hospital, Brookline, Mass., for 34 years, and served as executive director from 1950 to 1957.

Edward E. Johnston, M.D. — 66, died August 6.

Dr. Johnston had been manager, Nichols General Hospital, Louisville, Ky., from 1945 to 1947. A retired Army colonel, he had received the Army Commendation Ribbon for outstanding service.

Isidor C. Rubin, M.D.—75, internationally known gynecologist, died July 10. He developed the Rubin test for determination of sterility in women, and served as consulting gynecologist to Mount Sinai, Montefiore, Beth Israel, and Harlem Hospitals, all in New York City.

Sister Mary Depazzi, R.S.M.— died June 15. She had been a religious for 67 years and had spent most of that time at Mercy Hospital, Chicago, at which she was superintendent from 1920 to 1925. She had also worked in the drug room, surgical ward, and as operating room supervisor and local superior.

Ellen Stewart, R.N. — 89, retired administrator, Victory Memorial Hospital, Waukegan, Ill., died July 29. Until her death she was the oldest living graduate of the nurses' training school at St. Luke's Hospital, Chicago, having graduated in 1892.

VA Transfers Four To New Positions

New VA appointments include the appointment of Irving J. Cohen, M.D., to a newly created position as deputy to the assistant chief medical director for professional services, with offices in Washington, D.C.

Dr. Cohen was previously director of VA hospitals and clinics.

Lee H. Schlesinger, M.D., has been named VA area medical director, Columbus, O. Dr. Schlesinger, who was formerly manager, West Side VA Hospital, Chicago, succeeds John G. Hood, M.D., who is being transferred to Atlanta, Ga., as area medical director.

Dr. Hood is replacing Horace B. Cupp, M.D., who has been appointed deputy for operations, VA hospitals, outpatient clinics, and homes.

Wins VA Merit Award

Louis B. Newman, M.D., chief, physical medicine and rehabilitation service, VA Research Hospital, Chicago, has been given the VA's Meritorious Service award.

Dr. Newman, a physiatrist, was cited for outstanding service in organizing the research hospital's physical medicine and rehabilitation department and also, the center for rehabilitation of blinded veterans at the Hines, Ill., VA Hospital.

Two Generals Retire After 59 Years' Service

Gen. Armstrong

Gen. Maxwell

Brig. Gen. Earl Maxwell and Maj. Gen. Harry G. Armstrong, USAF (MC), have retired, completing a total of 59 years' military service.

Gen. Armstrong, who entered the Air Force in 1929, conducted many experiments which provided the medical knowledge necessary for flight at today's high altitudes and speeds. He also established the Department of Space Medicine in 1949, the first laboratory of its kind.

Gen. Maxwell has been assigned for the past two years as chief, medical division, 1002nd Inspector General Group, Norton AFB, Calif. He served 26 years as an Air Force flight surgeon, and during World War II, directed all activities for air evacuation of personnel in the Pacific area.

Air Force Announces Medical Staff Changes

Col. Larry A. Smith, USAF (MC), was recently assigned as deputy director of medical staffing and education, Office of the Surgeon General, U. S. Air Force. A specialist in internal and aviation medicine, Dr. Smith had commanded the U.S. Air Force Hospitals at Kessler and F. E. Warren Air Force bases.

Other staff changes announced by the Air Force surgeon general include these:

Lt. Col. Alice L. Montgomery, USAF (AFNC), has been reassigned from the consultants division, directorate of professional services, to the USAF Hospital, Chanute ABF, Ill., where she will be chief nurse.

Lt. Col. Louis F. Duquette, USAF (MSC), has been assigned as executive officer, USAF Hospital, Wimpole Park, England.

Lt. Col. Paul W. King, USAF (MSC), has replaced Lt. Col. Robert E. Clark, USAF (MSC), as chief, hospitals management branch, directorate of plans and hospitalization. Col. Clark has been assigned as executive officer, USAF Hospital, Sheppard ABF, Tex.

Col. Benjamin A. Strickland Jr., USAF (MC), has been assigned as Surgeon of the Air Defense Command, Ent AFB, Colorado Springs, Colo. He succeeds Brig. Gen. Albert H. Schwichtenberg, USAF (MC), who retired.

To Monitor
To Record
CARDIAC ACTIVITY
SIMULTANEOUSLY
during every operation

TWO NEW INSTRUMENTS BY BIRTCHER

to monitor
THE MODEL 360 CARDIOSCOPE

A superbly engineered new electrocardioscope for diagnosis and continuous monitoring of surgical procedures. New features include "no ghost" sweep, three trace speeds, remote control operation, ECG "hook-up" and an audible signal at no extra cost.

to record
THE MODEL 300 ELECTROCARDIOGRAPH

More than 19 engineering achievements are found in the New Birtcher Model 300 Electrocardiograph, including 2-speeds for 100% horizontal magnification, one-hand operation, standard 5cm size trace, transistorized printed circuits and a *full two year guarantee.*

The Anesthesiologist controls both of the units simultaneously, while seated in his normal position, with the compact Remote Control. Either, or both of the units can be located in another room if desired.

Write today for full color descriptives on the new Birtcher Model 300 Electrocardiograph and Model 360 Cardioscope — no obligation.

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THE BIRTCHER CORPORATION
DEPARTMENT HT-1058
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SEND ME DESCRIPTIVES ON YOUR NEW MODEL 300 ELECTROCARDIOGRAPH AND ON YOUR NEW MODEL 360 CARDIOSCOPE.

DR. _____
ADDRESS _____
CITY _____ ZONE ____ STATE _____

Bellevue Director Named VA Advisory Group Head

George E. Armstrong, M.D., director, New York University-Bellevue Medical Center, New York City, and vice-president for medical affairs, New York University, has been elected chairman, Veterans Administration Special Medical Advisory Group.

Succeeding Dr. Armstrong as vice-chairman of the group is Howard P. Rome, M.D., Rochester, Minn., Mayo Clinic staff member, and professor of psychiatry, Graduate School of Medicine, University of Minnesota.

Joint Council on Aged Names Executive Secretary

Howard I. Wells, Jr., Chicago, has been named executive secretary of the Joint Council to Improve the Health Care of the Aged.

Offices of the joint council are at 139 N. Clark St., Chicago.

Mr. Wells was previously executive secretary, American Association for Maternal and Infant Health.

The council was formed in April by the American Dental Association, the AHA, the American Medical Association, and the American Nursing Home Association.

Practical Nurse Education Group Expands Program

Expansion of the National Association for Practical Nurse Education's program for development of schools of practical nursing was announced recently by Hilda M. Torrop, association executive director.

The national group is doubling its organizational structure to include a new division of services to state associations to be headed by a licensed practical nurse. A registered nurse will direct the division of practical nurse education.

Among the services offered to state associations will be assistance in membership promotion, aid in securing speakers for state meetings and provision of convention exhibit material and literature, postgraduate courses for practical nurses, and extension courses for nurses licensed by waiver.

Heart Disease Center To Open in New York

Treatment and study of heart diseases will be conducted at a medical center to be opened this winter at New York Medical College, Flower and Fifth Avenue Hospitals, New York City.

Leo M. Taran, M.D., has been appointed director of the cardiopulmonary program which will coordinate surgical, medical, and psychiatric teams.

A new operating room will be constructed, with an operating table electronically equipped with audiovisual devices to pick up and record all vital processes. Heart surgeons in a lecture room will listen with headphones while watching a closed-circuit television screen. A permanent recording will be made for teaching purposes in other parts of the world.

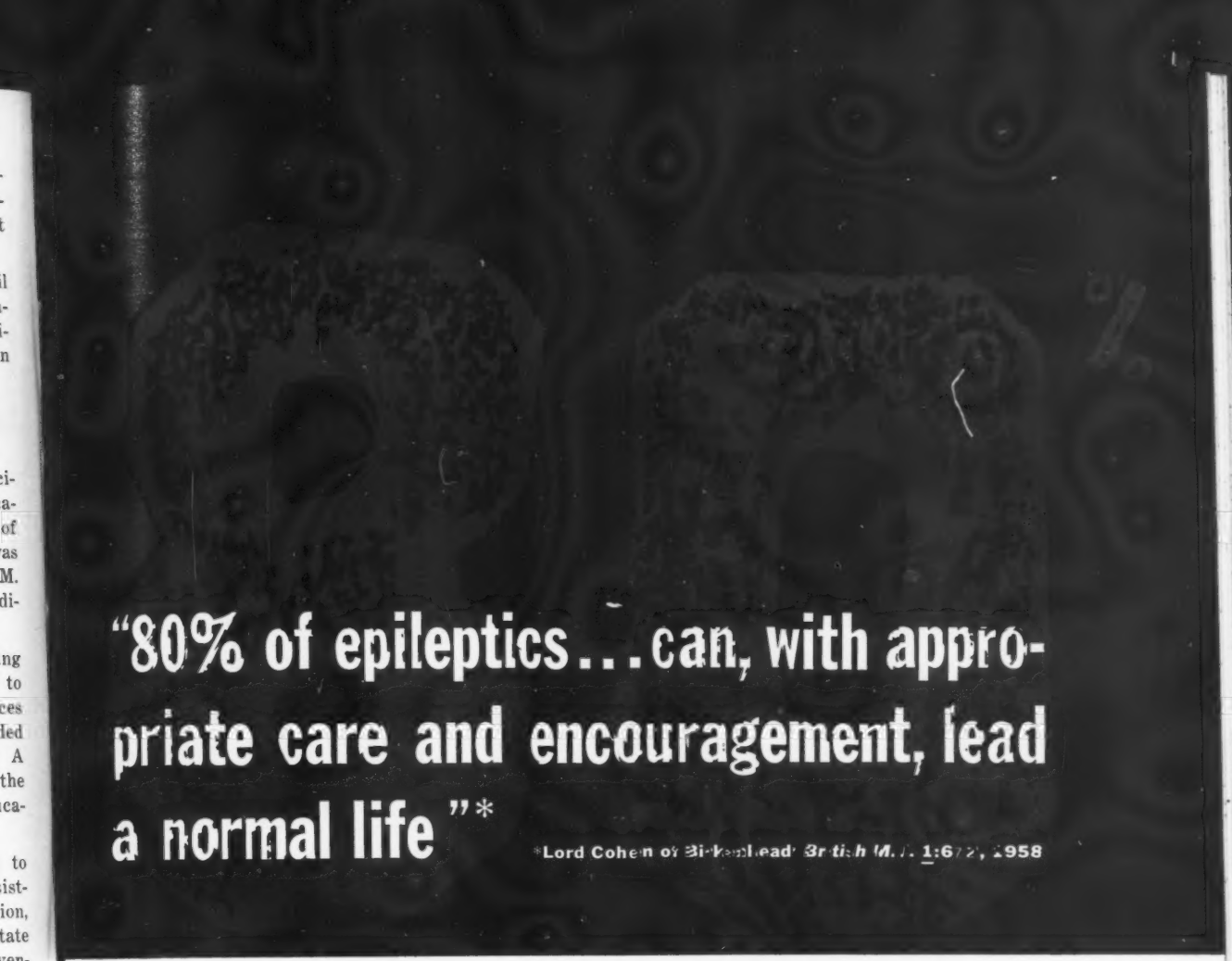
a superb aid[1]
in helping to prevent
and clear up
BED SORES
(DECUBITUS ULCERS)

DESITIN®
OINTMENT

Good medical and nursing care, and Desitin Ointment make an effective team in keeping the patient's skin soft, supple, and better able to resist and help heal bed sores. And for a very good reason: Desitin Ointment is effective in guarding against irritation which causes pressure sores. Its soothing, lubricant and healing influence is so persistent that one application protects the skin for hours.

SAMPLES on request
DESITIN CHEMICAL COMPANY
812 Branch Ave., Providence 4, R. I.

1. Grayzel, H. G., and Schapiro, S.: Western Journal of Surgery, Obstetrics and Gynecology, Oct. 1956.



"80% of epileptics... can, with appropriate care and encouragement, lead a normal life"*

*Lord Cohen of Birkenhead: *British M. J.* 1:672, 1958

the Parke-Davis family of anticonvulsants

...an appropriate anti-epileptic for every clinical need

for grand mal and psychomotor seizures

Dilantin®

Sodium (diphenylhydantoin sodium, Parke-Davis) is supplied in many forms—including Kapseals® of 0.03 Gm. and of 0.1 Gm. in bottles of 100 and 1,000.

Phelantin®

Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100.

for the petit mal triad

Celontin®

Kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100.

Milontin®

Kapseals (phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000. Suspension, 250 mg. per 4-cc. teaspoon, 16-ounce bottles.

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

MEDICAMENTA VERA

43090

Chicago Hospital Devises Patient Stationery Kits

Patients at Chicago Wesley Memorial Hospital can maintain contact with the outside world on exclusive letterhead stationery since the introduction of a patient stationery kit at the hospital.

The stationery is housed in a grey folder bearing a picture of the institution, an invitation to write someone, and the compliments of the hospital. Inside are 10 sheets of buff-colored stationery 6 by 9¼ inches in size, and five matching buff envelopes. Both are imprinted, in a warm green color, with the hospital's name and address.

On the inside flap of the folder is the message: "We thought you would like to have some special stationery to write to friends and relatives."

The kits, the idea of Ralph M. Hueston, superintendent, proved to be low in cost to produce. It is planned to have the folders distributed to all incoming patients by the hospital's volunteer group.

Heart Disease Research Furthered by Grants

Two fellowships at Children's Hospital of the East Bay, Oakland, Calif., are being supported by grants from the Alameda County Heart Association.

A total of $2,500 has been designated for the Norman B. Leet Fellowship, which has been awarded to Sanford Sherman, M.D., resident at Children's Hospital.

The second grant, of $3,000, is for investigation related to cardiac bypass surgery. The research is being done by Thomas C. Cock, M.D. Dr. Cock has completed two years of pediatric residency at Children's Hospital.

VA Hospitals to Study Neurological Diseases

Fifty-six VA hospitals and clinics will participate in a National Institutes of Health study of amyotrophic lateral sclerosis and related neurological disorders.

Brief patient case histories, blood samples, and saliva samples will be furnished by the hospitals to NIH headquarters in Bethesda, Md., where testing for specific blood types and for chemicals in saliva of patients with neurological diseases will be carried out.

Study Surgery for Stomach And Intestinal Ulcers

Effectiveness of surgery for stomach and intestinal ulcers will be studied by VA hospitals in Atlanta, Ga.; Bay Pines, Fla.; the Bronx, N.Y.; Des Moines, Iowa; Durham, N.C.; Long Beach, Calif.; Nashville, Tenn.; New Orleans; Syracuse, N.Y.; Tuskegee, Ala.; and Wilkes-Barre, Pa.

Records of veterans who underwent operations for ulcer of the stomach or adjoining portion of the small intestine during the past 10 years will be reviewed. A representative sample of the group will be recalled to the hospitals on a voluntary basis for a check on long-term results. Plans are to develop information revealing which operations promise the greatest benefit to individual patients under certain sets of circumstances.

The NEW
DUAL
PURPOSE
VASELINE
PETROLATUM GAUZE U.S.P.
STERILE
3 x 3 PAD, opens to 3 x 9 INCHES
TEAR HERE
3" x 9"
STRIP
Shorter length ends waste on small area wounds. New Z-fold insures perfect graft takes. Guaranteed sterile at time of use.
6th SIZE of
VASELINE®
PETROLATUM GAUZE
3" x 3"
PAD
Three-ply, fine-mesh gauze, lightly impregnated — for use in physician's office, industrial medical department, first aid.
Now supplied in:
1/2" x 72"
1" x 36"
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VASELINE is a registered trademark of Chesebrough-Pond's Inc.

THE TABLE OF TOMORROW—HERE TODAY...S-1501

SURG-A-MATIC BY SHAMPAINE

SURG-A-MATIC brings you many features that set new standards for major operating tables.

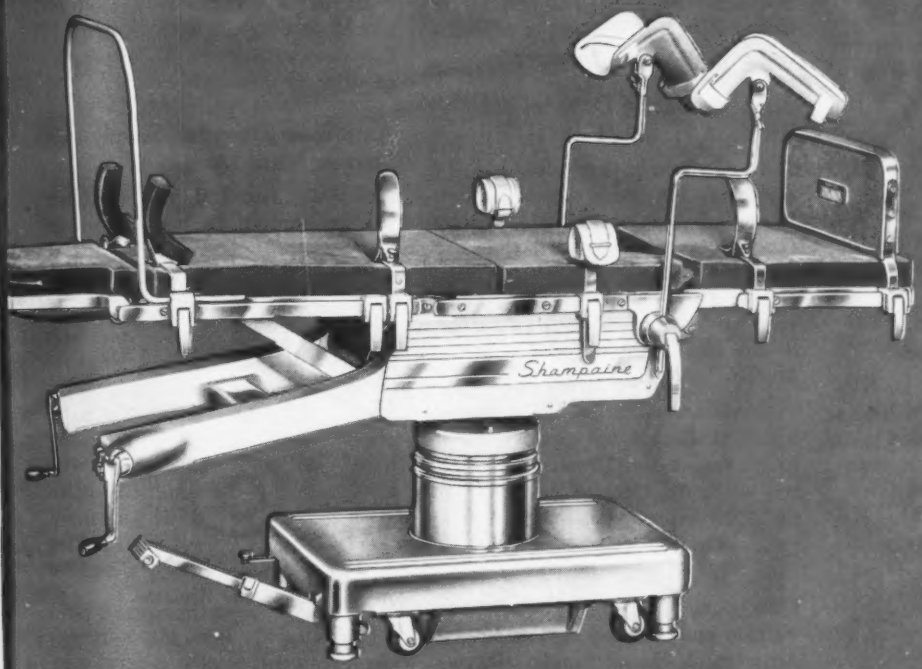
PUSH-BUTTON SHIFT—Ultra-convenient push buttons select all positions—conventional or extreme . . . including single adjustment proctoscopic, complete flex, reflex and kidney elevator. Push buttons eliminate visual attention.

TRUE HEAD-END CONTROL—All controls face anesthetist . . . outside draped and sterile field. Anesthetist remains seated. No search at sides of table to check indicators or reach controls.

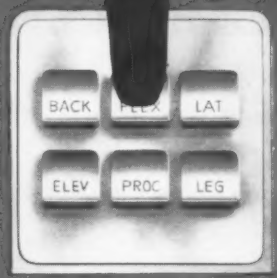
NEW BASES—Motorized or hydraulic . . . with new features for smoother, easier operation. No external housings.

FAST ACTING SIDERAIL CLAMPS—Eliminate broken or easy-to-lose set-screws. Accessories attached or detached with minimum effort and time.

NEWLY DESIGNED CRUTCH SOCKETS—Quick acting friction lock clamps speed adjustment of leg holders. Self-locking socket holds rod in any position . . . sockets easily removed.



FEATURING EXCLUSIVE PUSH-BUTTON SHIFT



JUST PUSH A BUTTON AND TURN HANDLE AT RIGHT TO REACH ANY OPERATIVE POSITION

Left handle controls independent Trendelenberg adjustments (maximum Trendelenberg in 22 turns). See new Shampaine positions below.

Shampaine COMPANY

1920 S. JEFFERSON • ST. LOUIS, MO.

a SHAMPAINE industry

SURG-A-MATIC provides table top heights from 27" minimum to 45" maximum.

SURG-A-MATIC provides kidney elevator adjustment off push-button shift.

SURG-A-MATIC provides complete 139 degree flex.

SURG-A-MATIC provides single adjustment proctoscopic position.

NEW BASES—MOTORIZED OR HYDRAULIC

Table top is supported by three widely spaced legs within pedestal. They provide maximum support to eliminate lateral whip of table top. No exposed keyways.

Flat stainless steel shield has integrally formed footrests to eliminate crevices and assure easy cleaning.

Motor concealed in base—no external housings. Motor listed with Underwriters Laboratories for class "1" group "C" atmosphere.

Downward strokes of pump pedal immobilize table on hydraulic self-leveling floor jacks. Upward pressure on pedal retracts floor jacks . . . table is then on easy to move three-inch ball bearing casters. Jacks provide firm support and are self-leveling on normal operating room floor.

TRADE TOPICS . . .

Roland F. Simons (c.), Ethicon, Inc., newly elected president, HIA, presents Harris L. Willits (l.), C. R. Bard, Inc., and Louis H. Nichols, Bauer & Black, with plaques for outstanding leadership and service at the HIA breakfast during the AHA convention in Chicago. Mr. Willits is immediate past president, HIA, and was a director from 1953 to 1958. Mr. Nichols served as a director during 1957-1958.

American Sterilizer Co. Forms Mexican Subsidiary

American Sterilizer Co. has formed a new subsidiary, Amsco de Mexico, S.A., which will engage in the manufacture, sales, and service of American Sterilizer's products in Mexico.

Other subsidiaries and affiliates of the company are located in Holland, Canada, Cuba, and Venezuela.

Clay-Adams, Inc., Appoints New General Sales Head

Leonard B. Niccum has been appointed general sales manager, Clay-Adams, Inc. He previously directed sales and advertising for Pitman Moore, and for Maltbie Laboratories Division, Wallace & Tiernan, Inc.

Bristol Laboratories Opens New Southwest Warehouse

Bristol Laboratories, Inc., has opened a new Southwest warehouse in the Brook Hollow industrial district outside of Dallas, Tex.

Charles Moore is manager of the center, which will serve Louisiana, Oklahoma, New Mexico, Arkansas, Mississippi, and Texas.

Bristol has also named three new district managers: Francis A. McNulty, Los Angeles district; Rudolph Ernst, Jr., Seattle, Wash., district; Stanley J. Blanchfield, Boston district.

Mr. McNulty replaces William G. Boyce who has been appointed to the newly created position of western regional sales manager.

John G. Searle Donates Student Health Center

John G. Searle, president, G. D. Searle & Co., and vice-president, board of trustees, Northwestern University, Evanston, Ill., has donated $800,000 for a student health center on the Northwestern campus. Construction on the two-story Searle Health Center will begin in March, 1959.

A medical education film produced by G. D. Searle & Co. was chosen to represent the United States in the scientific-didactic category at the 1958 International Film Festival in Venice, Italy, in July.

The color-sound film, "Edema in Congestive Heart Failure," was written and directed by Lee D. van Antwerp, M.D., of Searle. It was filmed in co-operation with Wayne State University College of Medicine and Wayne County General Hospital, Detroit, Mich.

Aeroplast Corp. Expands Sales Representation

Aeroplast Corp. has expanded its sales representation to 20 southern and midwestern states.

Englert Sales Co., Nashville, Tenn., is sales representative in Tennessee, Mississippi, Georgia, Alabama, and Florida.

Ar-Kay Industries, Inc., Cleveland, O., is the representative in Iowa, Illinois, Indiana, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, West Virginia, Wisconsin, and western Pennsylvania.

Denver Oxygen Co. Operations Revised

Four industrial and medical gas producing plants of the Denver Oxygen Co. will operate under the name of the National Cylinder Gas Division, Chemetron Corp., according to a recent announcement.

An NCG Rocky Mountain sales region was also established as part of the move integrating Denver Oxygen operations with the parent company.

Hayes W. Neil was named regional manager, with Edwin L. Lawson and Herbert H. Pollock, Jr., as district managers.

American Hospital Supply Names New Managers

American Hospital Supply Corp. has announced six managerial appointments.

Mr. Willman

Harry K. DeWitt, vice-president, has been named general manager, American Hospital Supply division, and John Willman, vice-president and manager, New York region, is new vice-president of operations of the division.

Christian G. Schmidt, a former vice-president, is now general manager, Scientific Products division, and his assistant, Jack N. Widick, has been appointed division manager, sales and merchandising.

New Scientific Products regional sales supervisors are Hale Erickson, formerly sales representative, Chicago region, now in San Francisco, and Thomas W. Chawk, formerly sales representative in the Columbus region, who has been transferred to Minneapolis.

Wendell Crain, formerly manager, Washington region, is New York regional manager. James S. Kennedy, Jr., assistant manager, New York region, has been named manager, Washington region.

Company representatives of the winning booths in the HIA technical exhibits competition at the AHA convention and competition officials are, from left: Robert J. Rodgers, St. Charles Manufacturing Co.; Richard J. Reilly, Dixie Cup Division, American Can Co.; Harry M. Tompkins, American Sterilizer Co.; Bremen I. Johnson, sales manager, AHA; William E. Smith, executive director, HIA; B. F. Bowles, Crane Co.; A. B. Gordon, B. F. Goodrich Co., Plastic Products Division; and Alfred A. Mannino, McKesson & Robbins, Inc. Grand Prize winners were American Sterilizer Co., booths over 200 sq. ft., and Crane Co., booths under 200 sq. ft.

HIA Exhibit Awards Given at AHA Convention

Grand prize winners at the third annual Hospital Industries' Association technical exhibits competition, held at the AHA convention, were the American Sterilizer Co., for booths over 200 square feet, and the Crane Co., for booths 200 square feet and under.

Honorable mentions for booths over 200 square feet were given to the St. Charles Manufacturing Co., and McKesson & Robbins, Inc. Honorable mentions for booths 200 square feet and under went to the Dixie Cup Division, American Can Co., and the B. F. Goodrich Co., Plastic Products Division.

Eaton Representative Honored

Charles E. Buell, Eaton Laboratories representative, has been chosen president-elect of the Medical Service Society of America, national association of professional detail men. The election took place at the society's recent annual convention in Detroit.

Smith, Kline & French Add Color TV Unit in London

Smith, Kline & French Laboratories has announced expansion of its closed-circuit medical color television services with the addition of a mobile color television unit in London for its British subsidiary.

The unit is the second of its kind in the world designed solely for medical use. One is already in use in the United States and another domestic unit is being considered. The units are used for postgraduate medical education.

Johnson & Johnson Forms New Sales Division

Johnson & Johnson has announced formation of a new hospital sales division in central United States, with James F. Molidor as manager.

Mr. Molidor

The division will include Tennessee, Missouri, Illinois, Kansas, Iowa, Nebraska, South Dakota, Kentucky, Indiana, and southern Ohio. Headquarters will be in St. Louis.

Stephen Georgevich succeeds Mr. Molidor as salesman in the Minneapolis territory.

Over one million injury-free man-hours of production during a 7-month period earned the Chicago plant of Johnson & Johnson a National Safety Council Award.

The award covered the period from October 24, 1957, to May 15, 1958, and represents the sixth time the plant has been cited for one million accident-free hours.

Since 1951, nearly 10 million man-hours of production at the plant have been accident-free.

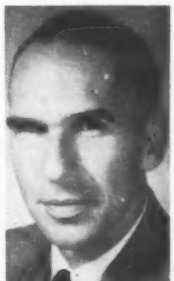
Research Specialties Co. Forms New Department

Research Specialties Co. has established a chromatographic materials department to provide a single source of supply for small lots of the substances and reagents used in chromatographic processes. The department will offer a complete selection, processed and repackaged in appropriate quantities for laboratory use.

Schering Officer Attends World Pharmacy Meeting

John N. McDonnell, Ph.D., vice-president, Schering Corp., attended the Federation Internationale Pharmaceutique in Brussels, Belgium, as one of eight delegates representing the United States. He was the official delegate of the American Pharmaceutical Association at the international pharmacy meeting.

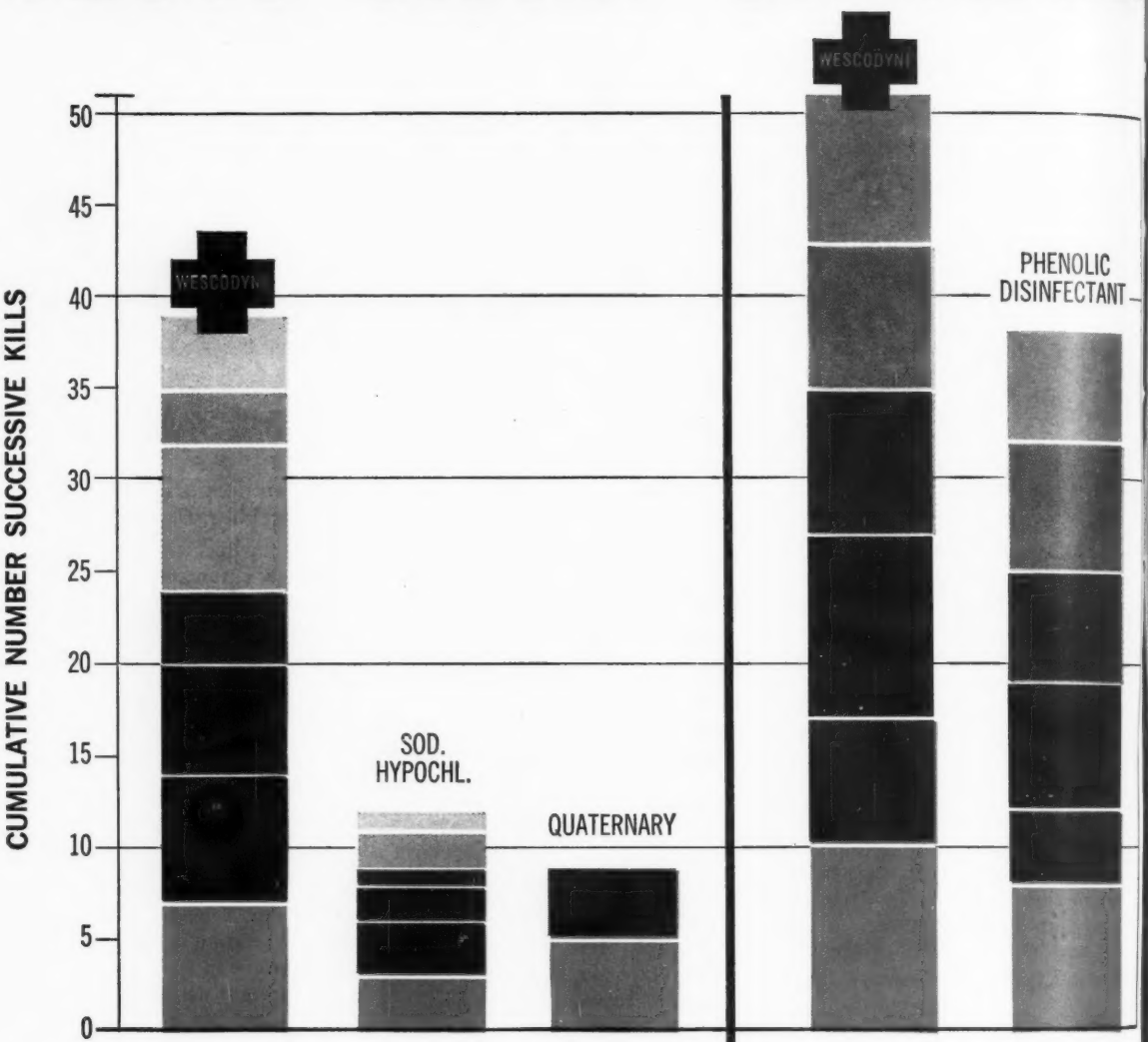
Picker X-Ray President Elected to C.I.T. Board



Harvey Picker, president, Picker X-Ray Corp., has been elected a member of the board of directors, C.I.T. Financial Corp. C.I.T. recently acquired ownership of Picker X-Ray, at which time it was stated that Picker would continue as an autonomous subsidiary of C.I.T.

(Continued on page 144)

TESTS SHOW GREATER



Capacity Test for Germicidal Action. (A. Cantor and H. Shelanski as described in Soap and Sanitary Chemicals, February 1951.) **Explanation:** This method essentially consists of adding to the use-dilution of the disinfectant or sanitizer, successive doses of a 50/50 mixture of milk plus broth culture of test organisms. These doses are added at ten minute intervals. Thirty seconds after each addition, a transfer is made into broth containing a suitable inactivator. This method makes it possible to determine the capacity of a germicide to kill before the micro-organisms and organic contamination have exhausted its germicidal action. **Organisms:** Salmonella typhosa, ATCC #6539; Micrococcus pyogenes. var. aureus, ATCC #6538; Salmonella pullorum, ATCC #9093; Pseudomonas aeruginosa, ATCC #8689; Trichophyton interdigitale Emmons 640, ATCC #9533; Penicillium luteum, ATCC #9644; Saccharomyces cerevisiae, ATCC #10274. **Dilutions:** WESCODYNE: 1:320 (50 ppm available iodine); Sodium hypochlorite: (100 ppm available chlorine); Quaternary: (50%) 1:5,000 (200 ppm active ingredient). **Temperature:** 15°C. **Media:** Fluid thioglycolate medium, USP XIII was used for testing WESCODYNE and sodium hypochlorite "Letheen" broth was used for testing alkyl dimethyl benzyl ammonium chloride.* All tests were re-subcultured in the same medium. **Results:** See above chart. **Conclusion:** The cumulative number of successful kills shows WESCODYNE to be over three times more effective than the nearest material tested.

*Neopeptone dextrose broth was used for testing the alkyl dimethyl benzyl ammonium chloride against the three fungi.

Wescodyne vs. Leading Phenolic Disinfectant. (A. Cantor and H. Shelanski Capacity Test as described in Soap and Sanitary Chemicals, February 1951.) The method used in this test is the same as that used in the Capacity Test for Germicidal Action described at left. **Dilutions:** WESCODYNE: 1:213 (75 ppm available iodine); phenolic disinfectant: 1:100 **Temperature:** 15°C. **Media:** Fluid thioglycolate medium, U.S.P. XIII was used for testing WESCODYNE and FDA nutrient broth was used for testing the phenolic disinfectant. All tests were re-subcultured in the same medium to eliminate bacteriostasis. **Results:** see above chart. **Conclusion:** This test shows that the bactericidal effectiveness (in the presence of organic contamination) of WESCODYNE at a dilution of 1:213 (75 ppm available iodine) is greater than that of a leading phenolic disinfectant at a dilution of 1:100.

PATHOGEN COLOR KEY:

- Salmonella typhosa (typhoid organism)
- M. pyogenes v. aureus (staphylococcus organism)
- Salmonella pullorum (poultry disease organism)
- Pseudomonas aeruginosa (wound contaminent organism)
- Trichophyton interdigitale (athlete's foot type of fungus organism)
- Penicillium luteum (mold organism)
- Saccharomyces cerevisiae (yeast organism)
- Strep. pyogenes hemolyticus (streptococcus organism)
- Escherichia coli (enteric organism)
- Shigella sonnei (dysentery organism)
- Salmonella schottmuelleri (food contaminent causing dysentery)

GERMICIDAL CAPACITY

WESCODYNE's advantages for the destruction of "Staph" as well as other disease producing organisms are extraordinary. Its greater germicidal capacity is shown at left. Two other features are equally outstanding:

❶ Nonselective biocidal activity offers wide-spectrum effectiveness — greater than that offered by solutions containing chlorine, cresylics, phenolics or quaternaries. It destroys organisms that range from mold to bacteria, viruses, spores and fungi. Antibiotic resistant strains of Staph are killed in 2 minutes at the general-purpose use dilution of 75 ppm available iodine.

❷ Labor-saving detergent action removes soil and dust as germs are destroyed. This simplifies procedures, including those for the control of dust that carries Staph and other organisms.

WESCODYNE is the single germicide suitable for all hospital cleaning and disinfecting procedures. Nonstaining, nonirritating, nontoxic at use dilution. Leaves no odor. The cost? Less than 2¢ a gallon at the general-purpose use dilution of 75 ppm available iodine!

WESCODYNE has an unmatched history of scientific evaluation and success. We'd be glad to send full information and recommended O.R., housekeeping and nursing procedures. Write West Chemical Products Inc., West Disinfecting Division, 42-16 West St., Long Island City 1, New York.

Programs and Specialties for
Protective Sanitation and Preventive Maintenance

WEST CHEMICAL PRODUCTS INC.
WEST DISINFECTING DIVISION

WESCODYNE®

FIRST "TAMED IODINE"® DETERGENT-GERMICIDE

(Continued from page 141)

National Laboratories Elects New President

M. E. Peck has been elected president and director, National Laboratories, Inc., subsidiary of Lehn and Fink Products Corp. Mr. Peck was formerly executive vice-president of National Laboratories.

Chemetron Corp. To Build Gas Plant in Erie, Pa.

National Cylinder Gas Division, Chemetron Corp., has broken ground for an industrial gas producing plant in Erie, Pa., to supply oxygen to hospitals in the Erie area, and to meet industrial needs.

The plant is being built in cooperation with Erie Forge & Steel Corp. and will provide the steel company with an uninterrupted supply of pipeline oxygen.

New Research Center Planned by Abbott

Abbott Laboratories has started construction on an eight-story glass and steel research center addition which will double space available for pharmaceutical research, development, and control.

In further expansion the company has opened a new distribution center and sales headquarters for the Texas area at 8001 Empire Freeway, Dallas.

News Briefs

John H. Brown, M.D.—has been named to succeed **B. Scott Fritz, M.D.**, as managing director of Wyeth Laboratories' biological laboratories at Marietta, Pa. Dr. Fritz will remain as resident officer. **Helmer P. K. Agersborg, Jr.** has become clinical physiologist, medical department, Wyeth Laboratories.

* * *

Harlan K. Young—is now Carolina Absorbent Cotton Co.'s sales representative for Illinois, Indiana, Kentucky, and western Tennessee. He has been with the company four years.

Carolina's new sales representative for western Pennsylvania, Delaware, Maryland, District of Columbia, Virginia, and West Virginia is **William H. Wilson.** In eastern Tennessee, and North and South Carolina, **James E. Brandes** is the new sales representative.

* * *

Aireactor Corp.—has moved its offices to 271 Madison Ave., New York 16, N. Y.

* * *

Roy Cramer, Jr.—has been named president, Cramer Posture Chair Co. **Harold W. Cramer** is the new executive vice-president.

* * *

Julian J. Bursten—has been appointed sales manager, Ketchum-Jersey division, Ketchum & Co., Inc. He replaces **David F. Goldstein,** who has been promoted to manager, New York division.

* * *

Paul W. Steen—has been appointed manager of distributor sales, Narda Ultrasonics Corp. He has taught electronic and commercial broadcasting, and was associated with Sperry Gyroscope Co., and Potter Instrument Co., Inc., prior to joining Narda.

* * *

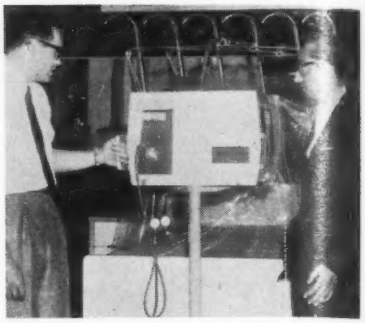
Fairleigh S. Dickinson, Jr.— president, Becton, Dickinson and Co., was one of three new trustees elected by the Hospital Service Plan of New Jersey (Blue Cross) at its recent annual meeting. He will serve a three-year term.

* * *

George M. French—has been appointed assistant sales manager, Bristol Laboratories. Previously, he was regional manager of the Southeast and Southwest areas.

* * *

Standard Packaging Corp. — has received approval from its stockholders to merge with Eastern Corp., Bangor, Me. It has also moved its offices to the J. P. Lorillard Building, 200 E. 42nd St., New York City.



Alejandro Gamero, M.D. (r.), San Salvador, El Salvador, watches demonstration of an O.E.M. oxygen tent by Victor Viglino, Shampaine Industries. Dr. Gamero recently completed three years of specialized study in surgery at Galveston, Tex. While there, he saw a Shampaine catalog, liked the products, and decided to visit the company's headquarters in St. Louis.

William F. Moos—has been named sales manager, South-Central region, Purdue Frederick Co. His territory includes Missouri, Texas, Oklahoma, Louisiana, Tennessee.

The firm has also appointed **Jack H. Keenan** manager, Northeast region, which includes New England, Pennsylvania, and Ohio. Mr. Keenan replaces **Murray Altman** who is now sales manager, New York metropolitan area.

* * *

Chester C. Ensley—has been named assistant to Norman A. Hansen, vice-president in charge of personnel and community relations, Abbott Laboratories.

Mr. McFadden

John J. Brennan has been promoted to field sales manager of Abbott's Chemical Sales Division. **Linton B. McFadden** has been appointed supervisor of the Abbott Memphis branch.

The company has moved its Buffalo, N. Y., distribution center and area sales headquarters to a new building at Abbott Mall near Walden Ave., Cheektowaga, N. Y.

* * *

Lewis C. Pape has been named general sales manager, foam division, Dayton Rubber Co.

(Continued on page 146)

INTERDEPARTMENTAL MEMO
COMMUNITY HOSPITAL

July 14, 1958

FROM: Secretary of Committee on Therapeutic Agents
TO: Committee Members
SUBJECT: Standardization of STERAJECT Injectables

A thorough review of techniques, procedures, products and devices, used by this and other hospitals for injectable antibiotic medication, has been completed. The study clearly indicates the need for the Steraject injection system for the following reasons:

1. ACCURACY OF DOSAGE--Single dose disposable cartridges provide an accurate pre-measured dose.
2. STERILE, DISPOSABLE NEEDLES--Sterile needles attached to Steraject cartridges provide a sharp needle for each injection and help avoid cross infection.
3. SAVE TIME IN CENTRAL SUPPLY--Steraject syringes eliminate cleaning, sterilization, assembly time and breakage.
4. SAVE TIME ON WARD--Steraject technique provides convenient, ready-to-use injectable medication.
5. IMPROVED INVENTORY CONTROL--Provides single unit dispensing for easier cost accounting.
6. LESS WASTE--Avoids partial use and resultant waste encountered with multiple dose vials.

The above reasons, plus proven convenience and economy, account for my recommendation that we adopt the Steraject line and standardize this system throughout the hospital.

Your early approval to standardize the complete Steraject line of injectables for use in the hospital, will be appreciated.

E. N. Separen
Chief Pharmacist

STERAJECT®

An economical, convenient and efficient method for minimizing injection problems and saving preparation time.

Single dose disposable cartridges with needle attached—use and dispose.

Available:

Penicillin G Procaine Crystalline in Aqueous Suspension 300,000, 600,000 and 1,000,000 units

Streptomycin Sulfate Solution, 1 Gm.

Combiotic Aqueous Suspension 400,000 units penicillin G procaine crystalline plus 0.5 Gm. dihydrostreptomycin

Dihydrostreptomycin Sulfate solution, 1 Gm.

Also available in cartridge without needle in hospital packages of 100.

Pfizer *Science for the world's well-being* **PFIZER LABORATORIES** Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y.

TRADE TOPICS

(Continued from page 144)

Joseph P. Kelley—has been appointed marketing planning manager, institutional products division, General Foods. He was formerly manager, eastern region.

* * *

Jack W. Ferguson—has been appointed Pacific regional manager, Woodlets, Inc., with headquarters in Hollywood, Cal. Mr. Ferguson will be in charge of distribution in the 11 states west of the Rockies.

* * *

Harry Cullumbine, M.D.—has been named vice president and medical director, Air-Shields, Inc. Dr. Cullumbine was formerly professor, and head, department of pharmacology, University of Toronto, Ont., Canada.

* * *

Eustace Lingle—has been named vice-president, industrial sales and education, Oakite Products, Inc. He has been with the company since 1929.

* * *

Ira M. Markwood—has been appointed manager, service division, Wilmot Castle Co. He was previously assistant service manager, Permutit Co.

* * *

Edgar A. Hawk, M.D.—has joined Mead Johnson & Co. as medical director, parenteral products division. He was formerly staff physician, Upjohn Co., and medical researcher with the U. S. PHS.

* * *

Nordson Pharmaceutical Laboratories, Inc.—is the new name of Nordmark Pharmaceutical Laboratories. Change was made to comply with trademark registration requirements in the U. S. and abroad. The company will continue to collaborate with Nordmark-Werke of Germany in research and in marketing products.

* * *

Central States Paper and Bag Co.—has appointed new representatives for Pro-Tex-Mor Disposable Medical Products. **J. Stone Carlson,** Needham, Mass., will cover the six New England states, and **Erwin Karson,** Miami Beach, Fla., will serve Florida, Alabama, Mississippi, and South and North Carolina.

* * *

Stanley S. Karafin—has been appointed manager, Eaton Laboratories' District 8, which includes Wisconsin, Michigan, and Illinois. He had been a representative in Oklahoma City, Okla.

* * *

Richard A. Lord—has been named manager, sundries sales department, B. F. Goodrich Industrial Products Co. He will direct sales of drug, surgical, and stationers' products. Mr. Lord has been with the company since 1938.

* * *

Edward Bilek—has joined Welton Laboratories as general sales manager, Nyal Co. He also will develop and expand Welton's Standard Drug Co. division. He formerly was with Purepac Corp.

* * *

Arnold O. Jackson, Ph.D.—has been appointed assistant director of clinical investigation, Crookes-Barnes Laboratories.

* * *

Donald P. Strohm—has been appointed supervisor, Scientific Products sales, division of American Hospital Supply Corp., in Columbus, O.

* * *

Ralph J. Richardson—has been named general sales manager, Cutter Laboratories. He was formerly manager, eastern division.

* * *

Edward C. Dixon—president, Continental Hospital Industries, Inc., has been appointed administrative consultant, hospital supplies and equipment, to accompany a team of doctors on a three-month round-the-world medical mission.

Thomas G. Allin, Jr., M.D.—has been appointed director, clinical research, Baxter Laboratories, Inc. Dr. Allin previously headed clinical research, Gillette Laboratories.

Baxter Laboratories has also named **Lincoln R. Dowell** to the newly created post of director of employee and public relations. He was formerly director, employee relations.

* * *

Eugene Fioramonti—has been appointed western regional sales manager, Narda Ultrasonics Corp. He was formerly associated with the Bendix Aviation Corp., and the Curtiss-Wright Corp. Narda also plans to build a sales office and warehouse in Los Angeles to service the West Coast.

* * *

William A. Gifford—formerly field service manager, American Sterilizer Co., is new service manager, Hill-Rom Co.

* * *

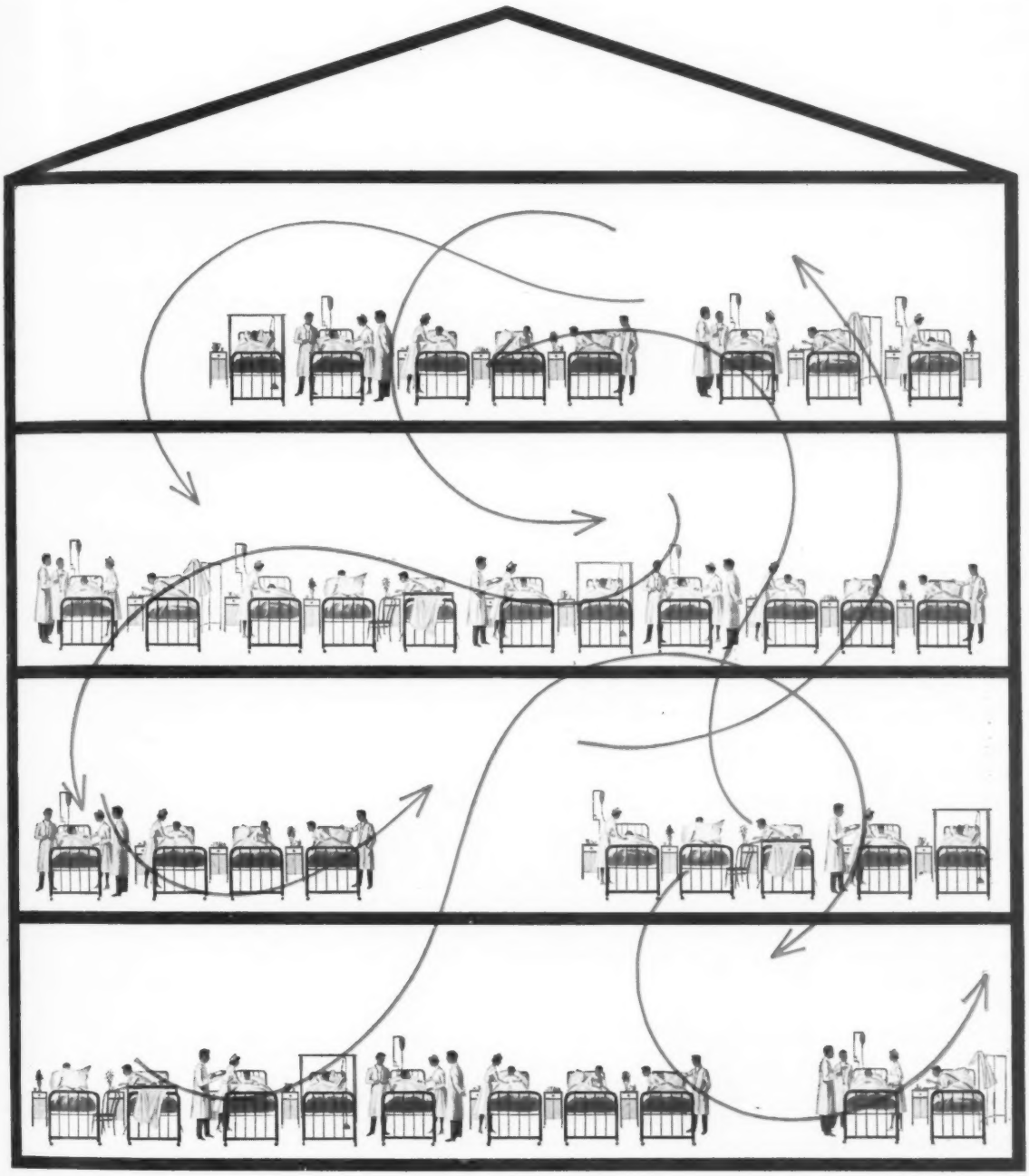
Robert P. Herwick, M.D.—has been appointed director of clinical research, Ethicon, Inc. Dr. Herwick was formerly medical director of Baxter Laboratories, has also taught pharmacology, therapeutics and medical jurisprudence.

* * *

A "piggyback" physician's sample package—suggested by Tom Fowler, Wyeth district manager, San Francisco area, recently received first prize in a nationwide competition sponsored by the Folding Box Association of America.

* * *

E. Roth Janes—has been elected vice-president for manufacturing, Chemway Corp. Mr. Janes was formerly vice-president, Warner-Chilcott Laboratories.



STOP "HOSPITAL STAPH" WITH ALBAMYCIN*

Antibiotic-resistant strains of Staphylococcus are meeting their match in Albamycin. Because Albamycin shows no cross resistance with any commonly used antibiotic, it is dramatically effective against unyielding staphylococcal pneumonia or superinfections of pneumococcal pneumonia.

Whether resistant staph is known or suspected, *Albamycin is indicated.*

ADMINISTRATION AND DOSAGE: The dosage for adults is 500 mg. Albamycin administered intramuscularly or intravenously every 12 hours. As soon as the patient's condition permits, parenteral Albamycin should be replaced with oral Albamycin therapy.

SUPPLIED: Available as 250 mg. capsules; syrup containing 125 mg. Albamycin per 5 cc.; and in the 500 mg. Mix-O-Vial.†

*TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF CRYSTALLINE NOVOBIOCIN SODIUM

†TRADEMARK, REG. U. S. PAT. OFF.

The Upjohn Company, Kalamazoo, Michigan

Upjohn

Army Selects 20 As Dietetic Interns

Twenty women, college graduates representing thirteen states and Puerto Rico, have been selected for participation in the Army Dietetic Internship program. They will be commissioned as second lieutenants in the Army Medical Specialist Corps, U.S. Army Reserve.

The intern program includes class work, projects, and practical experience at an Army hospital and is approved by the American Dietetic Association. Upon completion of the 12-month internship, the women will be assigned as dietitians to Army hospitals.

The program will begin with a 12-week orientation course at the Army Medical Service School, Brooke Army Medical Center, Fort Sam Houston, Tex. Following completion of this period, the dietitians will receive training in an Army hospital.

Assigned to Brooke Army Hospital, Fort Sam Houston, are: Joan L. Budzisch, Vivian S. Connelly, Priscilla DeJesus-Carrasquillo, Mary A. Helm, Colleen P. Lapcevic, Regina M. Onda, Iris Quintana-Medina, Bonnie M. Rehder, Barbara Ullrich, and Marilyn Scott.

Assigned to Walter Reed Army Hospital, Washington, D.C., are: Norma J. Bodie, Florence A. Burgly, Joan Forester, Dorothy Mount, Caroline Nizborski, Marie O'Brien, Sarah K. Swift, Patricia F. Tripp, Jane L. Welches, and Christine S. Cardwell.

Auxiliary Head Retires After Twenty-five Years

Mrs. William Harold Oliver, general chairman of the Branches (women's auxiliary), Children's Hospital of the East Bay, Oakland, Calif., will resign in February at the end of her twenty-fifth year.

Under her leadership, the group has earned almost three and three-quarters million dollars. Earnings have increased from $13,000 in 1934 to $356,083.27 in 1957.

Branch membership also has increased, from 500 women in 15 groups in 1934, to 3,000 women in 76 branches this year.

Hospital Council Names Advisory Board Chairman

George A. Hay, administrator, Hospital of the Woman's Medical College of Pennsylvania, Philadelphia, has been elected chairman of the advisory board, Hospital Council of Philadelphia, for 1958-1959. He succeeds Howard W. Baker, M.D., administrator, Temple University Hospital.

Boston Hospitals to Join In Nursing Care Study

Six Boston hospitals will participate in a study on how nurses' conflicts affect patient care in the outpatient department.

The study will be conducted by Warren G. Bennis, Ph.D., assistant professor of psychology, Boston University Human Relations Center, under a $29,710 grant from the U.S. Department of Health, Education and Welfare.

Data for the study will be collected by interview, questionnaire, and observation from nurses in the co-operating hospitals, which include Boston City, Massachusetts General, Massachusetts Memorial, Beth Israel, and Peter Bent Brigham Hospitals, and the Boston Dispensary.

The grant continues research which has been carried on for the past two years under the sponsorship of the American Nurses' Foundation, the U.S. PHS Division of Nursing Resources, and the Rockefeller Foundation.

Factors to be studied are: The discrepancies in expectations among members of the medical care team in the outpatient department; the relationship between the nurse and her supervisor; the differences in what the nurse expects from her job and what the job requires; and an analysis of the competition between the two demands made of a nurse—demands of patient care and organizational requirements.

CERVICAL+PELVIC TRACTION

WITH NEW DePuy TRACTION FRAME No. 700

Moves up with bed backrest!

This outstanding new frame can be quickly attached to any hospital bed. Supporting base clamps to bed spring frame, which permits elevating the entire frame with the backrest while cervical traction remains unchanged. The unit can be set up, as shown, eliminating the need for moving bed out from wall. Or, pulley-bar can be extended over head of bed if more convenient. For pelvic traction the unit is set up at foot of bed with pulley-bar inverted for greater height. Easy to use, sturdily constructed, folds flat for storage, and it's inexpensive. No. 700. Write for complete information!

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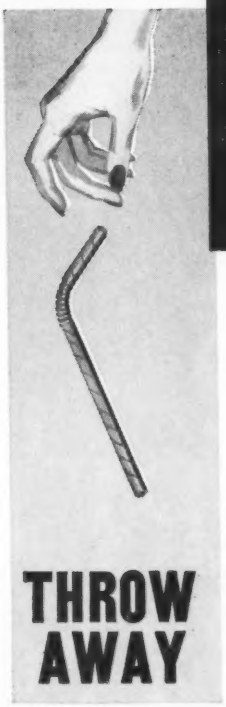
for HOT and COLD liquids



no sterilization!
no labor costs!

* send for hospital survey showing 27% savings

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Please send hospital survey and samples.

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Hospital_____

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you expect

ATARAX

(brand of hydroxyzine)

to calm your patients

BUT IN MANY DISORDERS YOU GET ADDED THERAPEUTIC BENEFITS

for example...

IN CARDIAC CONDITIONS

ATARAX *is anti-arrhythmic.* In addition to producing tranquilization, ATARAX "restored and then maintained normal sinus rhythm" in 30 patients with cardiac arrhythmias. All had been refractory to standard measures.[1]

IN ALLERGIC REACTIONS

ATARAX *is antihistaminic, antiserotonin.* Tranquilizers usually have an equivocal effect on allergic disease; ATARAX appears to be the exception.[2] Feinberg reports "striking results" in 15 out of 17 patients with chronic urticaria that cannot be attributed to calming action alone.[2] To date, over 649 cases of allergic dermatoses have responded favorably to ATARAX.[3,4]

IN GASTRIC DISTURBANCES

ATARAX *is antisecretory,[5] antispasmodic,[6] and antitensive.* Both emotional and physical aspects of gastric disorders are controlled by ATARAX. Treatment of peptic ulcer, epigastralgia, aerophagia with painful eructations, and colic of spastic origin, has yielded promising results.[5,6]

ATARAX®

FOR MORE THAN ATARACTIC ACTION

DOSAGE: *Adults,* one 25 mg. tablet or 1 tbsp. syrup q.i.d. *Children,* 1-2 10 mg. tablets or 1-2 tsp. syrup t.i.d.
SUPPLIED: Prescription only. *Tablets,* 10 mg., 25 mg., and 100 mg., bottles of 100. *Syrup,* pint bottles. *Parenteral Solution,* 10 cc. multiple-dose vials.

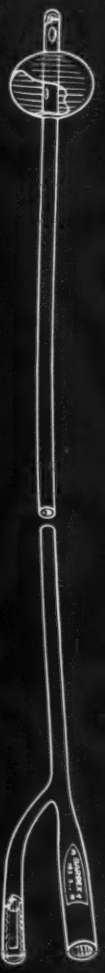
1. Burrell, Z. L., et al.: Am. J. Cardiol. *1*:624 (May) 1958. 2. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 3. Eisenberg, B. D.: Clin. Med. *5*:897 (July) 1958. 4. Robinson, H. M., Jr., et al.: South. M. J. *50*:1285 (Oct.) 1957. 5. Strub, I. H.: Personal communication. 6. Schuller, B.: Gaz. des Hôpitaux No. *10*:391 (Apr. 10) 1957.

ROERIG NEW YORK 17, N. Y. | DIVISION, CHAS. PFIZER & CO., INC. SCIENCE FOR THE WORLD'S WELL-BEING

these rigid specifications are

BASIC to BARDEX

for *perfected* performance



TIP	Not too short, not too long. Just right to ease insertion, not so long as to irritate bladder.
EYE	Properly placed and sized in strong, reinforced tip. Design that assures entirely proper drainage.
RIBS	To assure even distention of balloon—extra reinforcing rubber that also strengthens balloon. Tip held in proper position, too.
SHAFT	Smooth, round, with large lumen. Still another factor that means easy insertion, maximum drainage, and a minimum of patient discomfort.
PLUG	Easily punctured, self-sealing and always secure. Of specially compounded crepe latex, with long ridged side-walls, and cemented in inflation tube.
SIZE	Permanently shown by color patch. Identity not lost in autoclaving.

There is a difference . . . and just such "basics" as these tell you why "the standard of excellence" has long been BARDEX.

Of vital importance to hospital and patient is your specification of BARDEX, for dependable catheter performance.

BARDEX® FOLEY CATHETERS

More widely used throughout the world . . . than all other brands combined.

583 **C. R. BARD, INC.** SUMMIT, N.J.

STERILE in the durable, **easy-to-open package** that affords guaranteed protection . . .

ready for instant use without processing or autoclaving

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BUYER'S GUIDE

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602. Floor covering
603. Liquid dispenser
604. Deodorizer aerosol
605. Pharmacy bottle
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607. Resuscitation truck
608. Narcoti-counter
609. Fast-setting plaster
610. Autoclave label
611. Pretreated mop
612. Aerosol package
613. Refrigerator
614. Dietetic gum
615. Ultrasonic washer
616. Catheter plug
617. Switch for water softening equipment
618. Scale liners
619. Tube holder
620. Ladder
621. Fluothane vaporizer
622. Glass-marking stylus
623. X-ray film viewer
624. Baby cream
625. Disinfectant-detergent
626. Dynamometer
627. Artery graft
628. Mobile book truck
629. Pot and utensil washer
630. Oxygen tent
631. Viewscope
632. Invalid walker
633. Portable humidifier
634. Colostomy dressing
635. Flask
636. Key-filing unit
637. Knee-operated water mixer
638. Laundry spreader
639. Urine test unit
640. Paper cup holder
641. Electronic thermometer

FILMS, NEW LITERATURE

642. O.R. transportation
643. Psychiatric guide
644. Atomic models
645. Wall panels
646. Laboratory centrifuges
647. Fiberglas chairs
648. Antiseptic soaps
649. Hyperkinetic disorders
650. Scaffolding
651. Tax exemption

652. Ultrasonic cleaner
653. Kitchen chart
654. Cryogenic refrigerator
655. Packaged adsorbents

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C-660. Identification bracelet
C-661. Sterilized surgical gut
C-662. Surgical and medical glove
C-663. Tranquilizer
C-664. Plastic endotracheal tube
C-665. Ropeless laundry bag
C-666. Liquid soap
C-667. Hospital supplies
C-668. Wheel-A-Chair
C-669. Expendable syringe

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C-672. Glycol-ized air conditioner
C-673. Suction equipment
C-674. Obstetrical delivery table
C-675. Seamless tubular gauze
C-676. Oxygen control device
C-677. Detergent-germicide
C-678. Nurse education materials
C-679. Mobile automatic washer
C-680. Control syringe
C-681. Closed infusion system

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B-3	B-17	B-31	B-45	B-59	602	616	630	644	C-662	C-676
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B-5	B-19	B-33	B-47	B-61	604	618	632	646	C-664	C-678
B-6	B-20	B-34	B-48	B-62	605	619	633	647	C-665	C-679
B-7	B-21	B-35	B-49	B-63	606	620	634	648	C-666	C-680
B-8	B-22	B-36	B-50	B-64	607	621	635	649	C-667	C-681
B-9	B-23	B-37	B-51	B-65	608	622	636	650	C-668	
B-10	B-24	B-38	B-52	B-66	609	623	637	651	C-669	
B-11	B-25	B-39	B-53	B-67	610	624	638	652	C-670	
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B-13	B-27	B-41	B-55	B-69	612	626	640	654	C-672	
B-14	B-28	B-42	B-56	B-70	613	627	641	655	C-673	

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Chicago 2, Ill.

WHEN A TIME-TESTED PRODUCT GETS A NEW, TIME-SAVING PACKAGE...

RESULT... **ease of application** — while it's still in the package, blade can be attached to knife handle

RESULT... **strong, sturdy package** — puncture proof, moisture proof wrap withstands repeated handling and can be autoclaved

RESULT... **complete blade protection** — maximum sharpness of these traditionally superior **carbon** steel blades assured

Ask your dealer

It's Sharp

B-P Sterile Blade Dispenser Rack

BARD-PARKER COMPANY, INC.
DANBURY, CONNECTICUT
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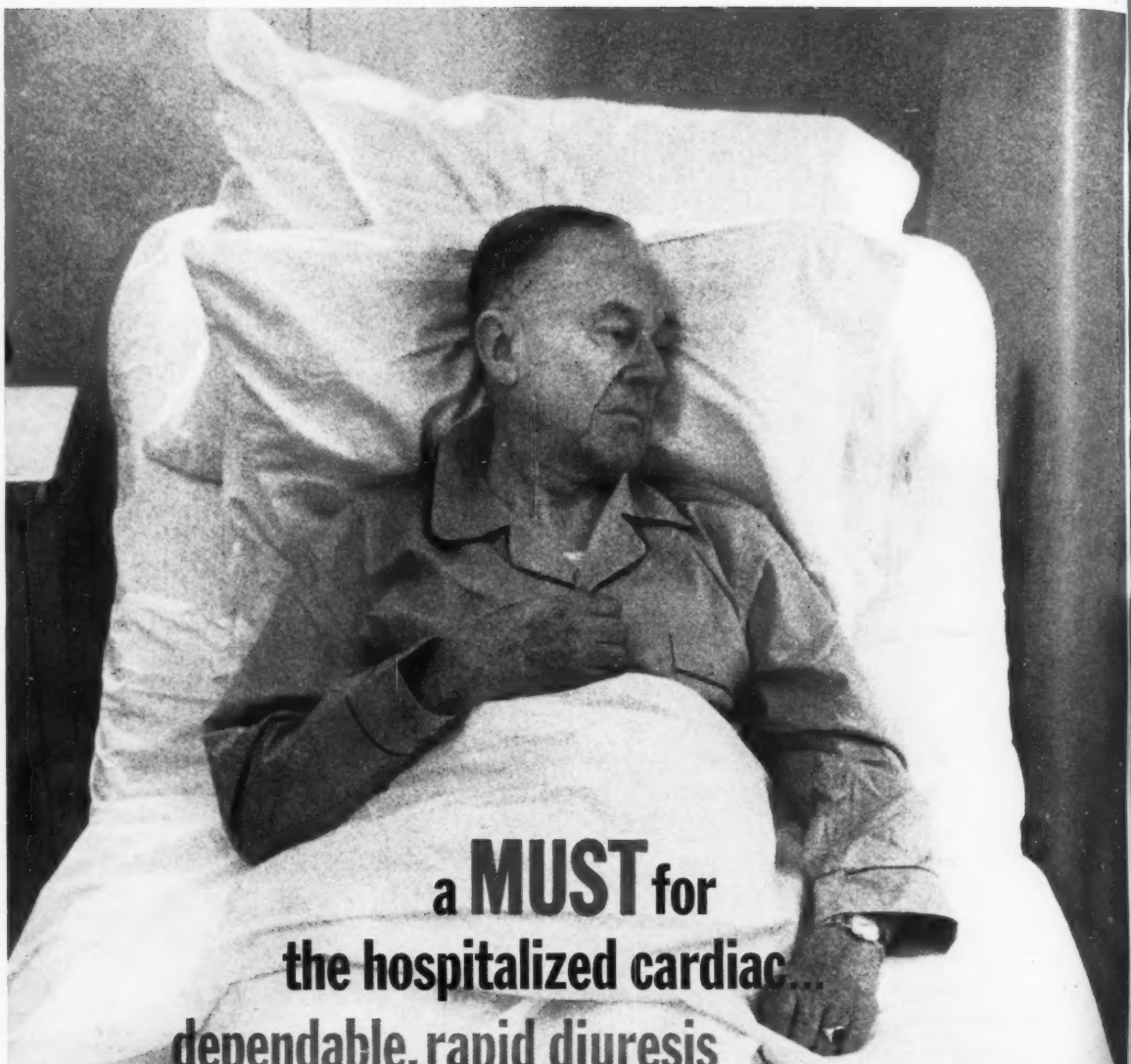

a MUST for the hospitalized cardiac... dependable, rapid diuresis

No one is more aware than professional hospital personnel that in acute fluid retention (cardiac failure), a diuretic regimen is a **MUST**. And the diuretic used **MUST** be dependable—**MUST** always provide maximum therapeutic benefits, rapidly, with minimal side effects.

For this reason, the standard procedure in the majority of hospitals is initial injection of **MERCUHYDRIN** to obtain the rapid, adequate diuresis that is often lifesaving.

Once acute symptoms have been controlled, **NEOHYDRIN**, the proved, effective oral diuretic, maintains the edema-free state.

The many years of dependable experience with **MERCUHYDRIN** and **NEOHYDRIN** have demonstrated that supplemental potassium is usually not needed, and other special diets are rarely required. Therefore, this diuretic team saves precious time for hospital personnel and patient alike—time that may be utilized by the staff for other hospital tasks; time that shortens hospital stays.

standard for initial control of severe failure

MERCUHYDRIN®
(Brand of Meralluride Injection) sodium

for maintenance of the edema-free state

TABLET
NEOHYDRIN®
(Brand of Chlormerodrin)

NEOHYDRIN®
WITH **VITAMINS**
(Brand of Chlormerodrin with B-complex and ascorbic acid)

LAKESIDE